PRINTED: 06/01/2017

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PRÓVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION .	(X3) DA	TE SURVEY
		· ·	A. BUILDIN	G:	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	MPLETED
		TN9002	B. WING_		ļ	
NAME OF	PROVIDER OR SUPPLIER		<u></u>		0.5	/17/2017
	RSTONE VILLAGE	2012 SHE	RWOOD D	, STATE, ZIP CODE	·	
		JOHNSON	CITY, TN	37601	•	,
(X4) ID PREFIX		EMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	
TAG N 000	THE TOTAL OR LE	C IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		· (X5) COMPLET DATE
14 000	Initial Comments		N 000			<u> </u>
J	Cornerstone Village Deficiencies were cit	nd investigation of complaints d#39008 were conducted at from 5/8/17 through 5/17/17. red related to complaints under Chapter 1200-08-06 g Homes.	·	•		
	1200-8-604(15) Adi (15)Each nursing hor policies for the protec accident and injury.	:	N 424	1. What corrective action (s) will accomplished for those residents found to have been affected by t deficient practice: Residents # 56 had his Care Plan revised on 5/10/17 by the Risk	1	6/1 5/17
t c e n a	Selt/Padded Lap Belt, observation, and interensing a safe and appearing the condition of th	e facility policy, review of stions for the Lap medical record review, view, the facility failed to propriate device for 1 (#56) ensure a restraint was (#59, #108) residents.		Manager to reflect his current or continued need for a restraint due spasticity and involuntary movements/shakes related to a traumatic brain injury along with restraint monitor and to obtain quarterly restraint assessment. An evaluation for a less restrictive restraint was completed on 5/11/1 by the Risk Manager to one on one	1 17	
R re all mate the re to no or ca	leview of the facility paviewed 7/14/16 reverse defined as any managed and the control of the facility of the	olicy Restraints undated, aled "Physical Restraints nual method or physical or aterial, or equipment the resident's body that emove easily which exemple or normal access restraints include, but are and lan trave the resident		monitoring and then reduced to a pelvic cushion and care plan was updated on 5/12/17 by the Risk Manager. On 6/6/17 a restraint assessment was completed by the Risk Manager and restraint discontinued. Resident was placed Rocking King wheelchair for mobility and safety by the Nursing Supervisor. Residents # 59 and #108 had their restraint reapplied correctly on 5/12/17 by the Risk Manager. The MD was notified of the restraint	in j	
		UPPLIER REPRESENTATIVE'S SIGNATU	<u>J</u> _	- A STOREGISTING		
	Jally	1	JRE	TITLE	ex	6) DATE
FORM				Administration	11.	<u>ج</u> آ ج

500PMT

PRINTED: 06/01/2017 FORM APPROVED

<u>Division of Health Care Facilities</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED TN9002 B. WING NAME OF PROVIDER OR SUPPLIER 05/17/2017 STREET ADDRESS, CITY, STATE, ZIP CODE CORNERSTONE VILLAGE 2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION /X5 PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 424 | Continued From page 1 issues with residents #56, #59 and N 424 cont. #108 on 5/17/17 by the Risk easily, that prevent the resident from rising ...Restraints may not be used or applied in a Manager. 2. How you will identify other manner, which causes injury to the patient...Physical Restraint Application...Apply the residents having the potential to be ordered restraint using the appropriate procedure. affected by the same deficient Follow the instructions provided by the practice and what corrective action manufacturer of the restraint... will be taken. All residents in the facility that have Review of the Application Instructions for the Lap a restraint were reviewed to ensure Belt/Padded Lap Belt revealed "...Position the the restraint is correctly applied per patient as far back in the seat as possible, with the application instructions and that the buttocks against the back of the chair...lay the they are in the correct devise. This lap belt across the patient's thighs...Bring the review was completed on 5/17/17 ends of the connecting straps down at a 45 bý the DON, ADON, Risk Manager, degree angle between the seat and the wheelchair [w/c] sides...crisscross the straps QA nurse, and RN Supervisor. behind the chair and draw them around the Beginning on 5/17/17 the correct opposite side kick spurs...kneel next to the back restraint application and correct wheel, outside...the wheelchair...Adjust the restraint devise with be monitored tightness of the slide buckles...check that the Q2Hrs by the medication nurses and straps are secure and will not change position, C.N.A.'s loosen, or tighten if the patient pulls on them, or if 3. What measures will be put in the chair is adjusted...The belt must be snug, but place or what systematic changes not interfere with breathing. To check for proper will you make to ensure that the fit, slide an open hand (flat) between the belt and deficient practice does not recur: the patient...There is a risk of chest compression A systematic approach to have or suffocation, if the patient's body weight is residents with restraints be assessed suspended off the chair seat... Monitor per facility for any type of restraint will be policy to ensure that the patient cannot slide reviewed and monitored for correct down, or fall off the chair seat and become restraint application and correct suspended...Stop use at once: if the patient has a tendency to slide forward or down in the device; type for restraint by the Risk or is able to self-release..." Manager beginning 5/17/17. The DON, Assistant Director of Medical record review revealed Resident #56 was Nursing and NEW Restraint Manager admitted to the facility on 1/20/15 and readmitted were in-serviced on 5/17/17 by the on 6/6/16 with diagnoses including Traumatic NHA on the correct type of restraint Brain Injury, Epilepsy, Dementia with Behavior for a resident, correct application Disturbance, Pseudobulbar Affect, and per manufacturer's instructions. Generalized Anxiety Disorder. Division of Health Care Facilities STATE FORM

ÇKDD

LW9W11

If continuation sheet 2 of 28

AND DI VN	NT OF DEFICIENCIES FOR CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	עיימיווחים יע (xs) אייניין (xs) אייניין	LE CONSTRUCTION 3:	EMOD (EX)	SURVEY
		TN9002	B. WINC_		051	7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE	1 001	11201
SORNER	RSTONE VILLAGE	2012 SUE	ת RWOOD	DIVE		
	—————	JOHNSOI	N CITY, TN	37601		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	:	T		
PREFIX TAG	RECUI ATORY OR I	Y MUST BE PRECEDED BY FULL SC IDEN'(TFYING INFORMATION)	ID PRETIX TAG	PROVIDER'S PLAN OF CORR. (FACH CORRECTIVE ACTION SECUROSS REFERENCED TO THE AP DEFICIENCY)	KOLLID RE	(X! COMP DAI
N 424	Continued From pa	ngc 2	N 424	4. How does the corrective ac	Lion(e)	·——
				will be monitored to ensure t	ho cont.	
- }	Medical record revi	ew of a Physician's Order		delicient practice will not reci	iri o	
ĺ	dated 1///16 reveal	led "D/C [Discontinue]		What quality assurance progr	ir, ne. am	
1	alarming self-releas	se belt. Apply soft belt restraint		will be put in place. Beginning	2111	
i	for hx [history] of fa	lls, poor safety awareness"		5/17/17 the NHA created an ad	edit	
į				tool to make sure that all restr	alate	
į	Medical record revi	ew of the Interdisciplinary		are correctly applied, monitore	ed for	
į	Mores dated 13/13/	16 revealed " Resident was all		correct application per instruct	lon	
	nis wheelchair and	Slid under his soft holt onto 🔠 🚶		and correct type is being used	lor	
1	the floor and bumpe	⊇d his bead on the food drive (the resident. Audits will be do	ac by	
- 1	um CNA [Certified N	Jursing Assistantj witnessed		the NEW Risk Manager, RN	н. с, ү	
- [will advente and	ted at this timeAs follow up,		supervisor, and Unit Manager,	Thou ·	
1	op"	on how to keep his scatbelt		will be done weekly x 4 weeks t	hen .	
	O11			monthly thereafter. The Risk		
Ì	Medical record revie	ew of the Interdisciplinary		Manager, and/or RN supervisor	will ,	
1	Notes dated 12/25/1	16 revealed "was called to		audit the residents who are in	·	
	resident by a memb	Of dietary staff to rapidous. I.		restraints for correct type for th	erie :	
	wite was siming on t	DE 1100r when this nume collect.	•	safety and correct application o	ег і	
	mm. izesidelit tisti s	iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii		Instructions. The goal of the au-	dit	
- 1	and moor after Mas 90	(empting to stand up from the L		will be 100% compliance. If the	goal :	
1.	noor by grapping an	Other resident's whaelchair - (-		is not met, then the identified st	aff !	
	nom the drick alua b	Uil himself up when his - L	-	member who is not meeting the	kost i	
	uarus supped and n	e fell backwards, hitting his	- 1	will be re-educated. Continued	ļ	
[]	read on the floor"	ŀ	1	failure to comply with the goal b	v :	
į,	Medical record ravia	Wala Thamas	į	 the identified employee will rest 	ilt in	
1 i	orm dated 1/5/17 re	w of a Therapy Screening	ĺ	progressive disciplinary action.	i	
	oite vhod/pninoitieou	nmentalready on case		- Beginning May, 2017, the DON v	AIT :	
ļ į	oad"			report monitoring outcomes of	}	
				restraint management auditing t	o i	
1 8	Medical record revie	w of the Physical Restraint		the quarterly QAPI Committee	!	
	reauction Assessme	ent dated 1/8/17 revealed		meetings. The Administrator will	r į	
1"	Slides downTota	Score4835 Inlust noor	- 1	report to the Governing Body	i	
Ca	andidate [for restr	aint reduction]"		concerning audits of restraint	ſ	
		- I		Outcomes on a quarterly basis	ļ	
Ī	/ledical record review	w of the interdisciplinary	ĺ	beginning 6/21/2017	!	
	voies dated 1/12/17	revealed "Resident has			1	
1 0	ontitued to remove the it is placed on hi	his soft belt device every			}	
l u	the it is placed on hi th Care Pacilities	m"			:	

LW9W11

If confirmation phoof, 3 of 28

Division of Health Care Facilities FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED TN9002 B. WING <u>05</u>/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CORNERSTONE VILLAGE 2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601 (X4) ID 💠 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 424, Continued From page 3 N 424 Medical record review of the Interdisciplinary Notes dated 4/13/17 revealed "...Resident observed trying to remove self from wheelchair multiple times this PM, [evening] Resident laying down in wheelchair, attempting to get out of ordered soft belt multiple times. Resident placed back in bed prior to dinner tray served..." Medical record review of the Interdisciplinary Notes dated 5/9/17 revealed "...nurse notified to assist resident by visitor to building, resident noted to be attempting to slide out of wheel chair and under soft waist belt. Residents legs were up on chair next to wheel chair...nurses assisted resident up in chair and released soft waist [belt]. Nurse asked resident if he was wanting to lay down, resident shook his head yes. Staff immediately helped resident in bed...no skin tears or bruising noted..." Observation on 5/9/17 at 2:00 PM, revealed the resident in a high back wheelchair in the common area on the upper floor. Continued observation revealed, as approaching the Nursing Station, was summoned by another resident pointing at Resident #56. Continued observation revealed Resident #56 had slid down in the wheelchair, with his feet up on another chair in front of him. Continued observation revealed a soft waist restraint had slid up towards the resident's neck, with the restraint straps noted to be down between the sides of the wheelchair, crossed behind the resident, and looped over the kick spurs. Summoned Licensed Practical Nurse #1(LPN), who was standing at the medication cart on the other side of the nursing station, to assist Resident #56. Interview with LPN #1 on 5/9/17 at 3:00 PM, at Division of Health Care Facilities STATE FORM LW9W11

If continuation sheet 4 of 28

	Division of Health Care Faci	<u>lities</u>			FORM APPROVED
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		TN9002	B. WING	····	05/47/05 47
,	NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS CITY S	STATE, ZIP CODE	05/17/2017
••	- CORNERSTONE VILLAGE	2012 SH	ERWOOD DR	IVE	
		JOHNSÖ	ĬŇ ČĬŤŸ, TŇ Š	37601	
	TAG REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ID BE COMPLETE
i	N 424 Continued From pa	ge 4	N 424		<u> </u>
	walst belt had come with the resident's ke and the resident's rise resident. Continued released the soft be stated the resident v	•			· ·
	5/9/17 at 3:30 PM, in confirmed the wheel wheelchair with anti- of the wheel chair. C	ecision making to use the coff			•
	i resident soated in a	17 at 5:50 PM, revealed the high back wheelchair, in the upper floor, with the soft belt		-	
	. j ute opstairs Nursing	3 on 5/10/17 at 7:55 AM, at Station, confirmed the under the soft belt and tries belt.		•	
	the common area, co the resident slide down Continued interview of	3 on 5/10/17 at 8:00 AM, in onfirmed CNA #3 had seen on in the wheelchair. confirmed "he starts getting out, and slides down in the			
	seated in a high back restraint in place.	sident on 5/10/17 at 2:25 rea, revealed the resident wheelchair, with a soft belt			
Uh St	vision of Health Care Facilities ATE FORM	· · · · · · · · · · · · · · · · · · ·			

LW9W11

If continuation sheet 5 of 28

SIAITME	n of Health Care Fa NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CHA	TANADOTES	F OOMETS.		MAPPRO
ለክር ትርላክ	OF CORRECTION	IDENTIFICATION NUMBERS	A. DUILDING:	E CONSTRUCTION	(X3) DA	ALC SURVEY
			Octobrillands		60	MPQ, ILD
		TN9002	B. WING			
NAME OF	PROVIDER OR SUPPLIEF	41.10	<u> </u>		0:	5/1 <u>7/20</u> 17
•		31KLETAD	DRESS, CITY, S	HATE, ZIP CODE		
	RSTONE VILLAGE	IOTINSON	RWOOD DRI	IVE		
(X4) (i)	SUMMARY ST	ATLMENT OF DESPRISATION		— · · · · · · · · · · · · · · · · · · ·		
PREFIX	VANOU DECUMENT	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID : PROFIX {	PROVIDER'S PLAN OF COL (LACH CORRECTIVE ACTION	RECTION	(X5
	:	ESC IDEIALB. AIMS INLOKWATION)	TAG	GROSS-REFERENCED TO THE	ALLKOLKIVIE PUONIN PE	COMPO DAT
N 424	Continued From pa			DEFICIENCY)		į
			N 424			
	Interview with CNA	\#5 on 5/10/17 at 2:35 PM, in	İ			
	THE SOOTHWE COURT	Med "The slidge out under his I				
	out"	elt is tighter he manages to get				:
	out	!	ł			i
;	Interview with tieses	proof Physical Physic	ļ			
	Assistant #1 (LD PA	nsed Physical Therapist a) on 5/11/17 at 8:05 AM, in the				:
	THE GUY DEBARIME	DI CODDITIONAL (b. a.]			į
	on over little DISCO	2IBDOS to bull his foot up and t	Ţ			i
	gets in fetal position	n in the wheelchair"	Ì	•	•	:
						:
	Interview with the L	Director of Nursing (DON) on				
	*** ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	ID ING CONFORMAC PAGES				į
	Action Control of the lating	I Was award Dagidage ten I				1
:	Was at risk for each	and confirmed Resident #56 ous harm, injury or death.	1			Į
			,			
į	Interview with CNA	#7 on 5/11/17 at 9:40 AM, at				1
	me obetons wittellf	Lightion confirmed CMA 47 L	{			-
i	ana ocen me teside	Sill Slide under the coff both. L	1			!
	with the soft belt in I	place on the wheelchair,				1
		Į.				1
j ,	MESSION FAMILY CNA	#3 (CNA assigned to Resident				1
	2007 200 37 (11 17 31 7	UDU ANE OF the EAR Care	1			
ii	he wheelchair in the	had gotten the resident up in coming and hoped he				!
Įv	Would sit for a lew m	ninutes. Further interview	ļ			1
	vanannea (ne CNA)	13d found the resident on the L			•	
1 1	ioni severar (Imies 9	fier he had elid out of the	1			ł
įν	vneeichair under the	e belt, "don't know what to do ∫	1			ļ
į te	o fixpicked him up	more than once."		•		Ì
÷			1			ļ
i Ç	wservation on 5/11,	/17 at 9:55 AM, revealed	ļ			į
	769 SEW 004 III WOO	taled in a high hook - 1				ĺ
, 1 W	ingalorali ili (10 113) Presidenti ili (10 113)	I. Continued observation	}			
	avealed resident #5	56 was sliding down in the				!
re	esidend's larga was	soft waist belt up over the	1		i	
i n ∤a.	nd his buttocks of	his arms above his head of the wheelchair seal, LPN	ł		Į	
1 22.	ar aremound at the W	edication cart at the upper			ſ	
a af I land	h Care Facilities	and the upper			ŀ	

пими

1.W9W11

If continuation sheet 6 of 28

PRINTED: 08/01/2017 FORM APPROVED

AND DIAM OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLTIDE	E CONSTRUCTION		
7 110 1 CAN O	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	- CONSTRUCTION	(X3) DA: CO!	TE SURVEY
			1			
NAME OF ST		TN9002	B. WING		05	/17/2017
MAME OF PRO	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		,
GORNERS:	TONE VILLAGE	2012 SHE	RWOOD DRI	VE		
/VALID		JOHNSOI	V CITY, TN 3	7601	****	
(X4) IĐ PREFIX	ICAUM DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CO	RRECTION	. //
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE	LSHOULD DE	(X5) COMPLE DATE
N 424 C	ontinued From p	2006		DEFICIENCY)		i
			N 424			_
e: c=	id of the hall, wa	s summoned to assist the	İ			į
re	Sident slid out or	d observation revealed the nto the floor under the soft waist	1			İ
be	elt.	to the noor under the soft waist				;
_	_	ļ	1			•
0	bservation of Res	sident #56 on 5/11/17 at 10:00	J			
/u	VI VYKUI LIZIN 1774 . TE	EVERIED the regident on the bent	}			į
, 4-	rated it title than I	DRCK Wheelshoir Continued				
ha	id slid under the	terview revealed the resident soft waist belt onto the floor,	i			
, Wi	th the soft belt in	tact, and the straps were	1			į
. DG	and the tesideble	STO Criss crossed over the				1
PAIC.	novuis. Continue	2d Observation revealed the	l	•		İ
	andants 91102 Mei	TE above his bood Continued 1.	1			1
0.0	aei valion teveale	I watered Abureine Assistant 109]
, on	the same hall to	t of the Rehab Therapy room assist LPN #4 with the	[ĺ
res	sident.	assist LPIN #4 With the				
Int	erview with CNA	#6 on 5/11/17 by telephone at				{
	A 1. MY COUNTILLIED	UNA #6 saw the registers	ł			į
; - 2114	ie wilder His soπ	Delt While in the wheelers !	ł			ĺ
3 1 12	i oi i o. Gontinued	Interview confirmed be	ļ]
*****	gles and slides u	inder the belt.				
; Me	dical record revie	w revealed Resident #59 was	Ī			1
; =41	man to the 19011	IV OD 8/10/15 with discourses. J	ŀ			
1 11101	annia myberreuz	IOD, AlZheimer's Domanija – I	j			
(An	riety, Depression	and Psychosis				ı
Ohs	servation and into	erview with RN #1 on 5/8/17	1			
at 4	:15 PM, in the 50	00 hallway near the elevator,				
1,000	aleu Keşiqent#	59 Was seafed in a	ſ		i	
. WDE	eichair with a so	ft lap belt applied, and the				
1,001	rent uso silo dol	VD ID the Wheel chair with the (1	
; 5010	rap beit around i	ner chest, just under her	}		l	
: Drea	isi, Continued in	CPView revealed RM ***	1		j	
; Wro	od We need to ke	we put these on. If doing it ow it" Interview confirmed			ŀ	
1 1/14	#1 thought the re	estraint was applied correctly.				
	are Facilities		្រ			

TIM6MT

If continuation sheet 7 of 28

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: .		E CONSTRUCTION	(X3) DATE SURV COMPLETE	EY
}		TN9002	B. WING	<u></u>	05/17/20	17
-	NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	90111720	**
-4	CORNERSTONE VILLAGE	2012 SH	RWOOD DR	IVE		
H	(24) 10	JOHNSO	N'CITY, TN 3	<u> 7601</u>	• • • •	
	TAG REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ISHOUIDEE ! com	(X5) MPLETE DATE
	N 424 Continued From pa	age 7	N 424			
	at 4:25 PM, on the revealed the CNA to chest level because would scoot around in a geri chair, I do chair with the belt revealed, after revisinstructions, CNA following the manuse of the restoration and in at 4:30 PM, on the confirmed the resident around the resident and needed to be to Resident #108 was 6/3/16 with diagnost Fractured Right Ace and Anxiety Disorder Medical record revisit dated 6/11/16 reveals	admitted to the facility on es including Dementia, etabulum, Muscle Weakness, er. ew of a Physician's Order aled "apply soft helt to wic				
	preventing falls"	es [resident] is up due to				
	Medical record revie Evaluation dated 6/1 "Recommendation [wheelchair]"	ew of a Pre-Restraint 11/16 revealed as: soft belt while in w/c				
	Director of Nursing (PM, in the common revealed the residen with a soft lap belt in observation revealed	i the left strap was between		,		
L Divis	the seat and the whe sion of Health Care Facilities TE FORM	eelchair side, crossed in				

LW9W11

If continuation sheet 8 of 28

<u>Division of Health Care Facilities</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMP) FTFD TN9002 05/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CORNERSTONE VILLAGE 2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEPICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX (XB) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 424 Continued From page 8 N 424 , back, and looped over the kick spur. Continued observation revealed the right strap was over the wheelchair side, crossed in back, and looped over the kick spur. Continued interview confirmed the lap belt had been applied incorrectly. N 601 1200-08-06-.06(1)(a) Basic Services N 601 1. What corrective action (s) will be 6/15/17 Performance Improvement. accomplished for those residents found to have been affected by the (a) The nursing home must ensure that there is deficient practice: an effective, facility-wide performance Beginning 5/12/2017 the NHA & improvement program to evaluate resident care DON reviewed and revised the QAPI and performance of the organization. Plan and was presented at the 5/30/2017 QAPI Committee meeting along with an updated standardized This Rule is not met as evidenced by: agenda to ensure all topics related Based on facility policy review, review of to the survey deficiencies are manufacturer's instructions, medical record review, observation, and interview, the facility reviewed at the QAPI meetings. failed to implement a program for the Beginning 5/12/2017 the QAPI Committee meetings reviewed the management of restraints. monitoring tools established by the The findings included: NHA, DON & approved by Medical Director. The NHA & DON Interview with the Medical Director (MD) on developed monitoring tools for Use 5/11/17 at 8:45 AM, In the conference room, of Restraints, Restraint assessment confirmed the MD attended Quality Assurance and evaluation, Resident Rights for meetings and made no recommendations for ADL documentation per care restraint reductions in the facility. plan/nutrition intake/weights, Infection control - hand hygiene Interview with the facility Administrator and following procedure and not Licensed Practical Nurse (LPN) #1 on 5/11/17 at changing gloves, answering call 4:34 PM, in the conference room, revealed the lights, improper administration of Quality Assurance (QA) team, including all drugs - mixing two insulin disciplines, meets every other month, and the Medical Director has input with addressing medications, current & appropriate interventions on care plans, concerns. Further Interview revealed the QA team discussed the number and type of restraints. incomplete documentation by cont. Licensed staff, & staffing levels. Division of Health Care Facilities

STATE FORM

dana

LW9W11

If continuation sheat 9 of 28

	Division of Health Care Fac	<u>ilities </u>			FORM	APPROVED
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUE	TIPLE CONSTRUCTION		
	S S S S S S S S S S S S S S S S S S S	IDENTIFICATION NUMBER:		NG:	(X3) DATE	Survey Pleted
	ł	Į	7 - 7,4-		COM	,reien
		TN9002	8. WING		ı	
	NAME OF PROVIDER OR SUPPLIER				05/1	7/2017
		STREET A	<u>DORESS, CO</u>	Y, STATE, ZIP CODE		
	CORNERSTONE VILLAGE	2012 SH	ERWOOD	DRIVE		
	(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	N CITY, T	N 37601	, , , , , , ,	
	I THE IN . LEACH DEFICIENCY	MUST RE DDECEDER MAGNI.	JD DDGE***	PROVIDER'S PLAN OF CORRECTION	N	(35)
	i vya vegoryjoka ók ri	SC IDENTIFYING INFORMATION)	: PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	1 □ =	COMPLETE
	N 494 O #		<u>i</u>	DEFICIENCY)	ZIMIE	DATE
	N 424 Continued From page	ge 8	N 424		- ,- 	
	, back, and looped ov	er the kick spur. Continued	1	[J	
	COSEL ACTION TRAGSIG	(i the right stran was availth.	Ì	-		
	marcollial side, cm	SSGC in hack ちゃき (5	į	ľ	
- 1	. Avei me kick soff. (iontinued interview so-c			J	
-	the lap belt had beel	n applied incorrectly.	!			
			i	1		
ĺ	N 601 _. 1200-08-0608(1)(a) Basic Services	N 601	·		
- 1			[2. How you will identify other	cont.	
- 1	(1) Performance Im	provement.	į	residents having the potential to b		
	(a) The nursing how	30 must (1	į	affected by the same deficient	oe	i
1	an effective, facility-v	ne must ensure that there is		practice and what corrective actio	_	
- 1	myprovernent brodra	M to evaluate recident age.		will be taken.	n	ŀ
- [and performance of	the organization		Effective 5/12/2017 the NHA will		i
ŀ	i i			ensure the Medical Director is	ĺ	
	This may			provided time to evaluate	1	1
1	This Rule is not met	as evidenced by:		Clinical concerns and resident care	,	
-[Based on facility police	Cy review of		policies and procedures before the	1	
Ţ	review. Observation	ctions, medical record and interview, the facility		meeting to ensure a coordinated	1	!
1	falled to implement a	nrogram for the		effort of timeliness in addressing		İ
	management of restri	eints.		quality of care issues.		ł
	ļ	Į.		3. What measures will be put in	- 1	1
	The findings included	: }		Prace or what systematic changes]	1
1	Intensional			will you make to ensure that the		
1	Interview with the Med	dical Director (MD) on		deficient practice does not recur:	İ	ĺ
	COnfirmed the MD atta	the conference room,		On 5/30/2017 the NHA developed	- 1	ì
1	Meetings and made h	ended Quality Assurance o recommendations for		Quality Improvement Objectives for 2017 to be presented at the QAPI	' Î	- 1
1	restraint reductions in	the facility		committee meeting. On 5/12/2017	- 1	
		· .		the Governing Body provided the		1
]	Interview with the facil	ity Administrator and]	facility NHA with resources and		1
-	Liconaed Fractical Mili	(Se (LPN) #1 on 5/44/47 🛶 📗		education materials for QAPI,	ĺ	
ĺ	Liver in the Coulde	ence form ravesled the li		including but not limited to the OAD!	. 1	ĺ
1) woolity Assurance (C)A	A) team including all		root Kit, QAPI at a glance, and a		- 1
	i woodpilites, meets ever	O Other month and the	ľ	resource guide to effectively		
j	Livicalcal Dilector USS It	IDUI with addressing	1	implement the QAPI plan		
ļ	discussed the number	view revealed the QA team	ļ	4. How does the corrective action(-)	[-	- 1
		and type of restraints.		will be monitored to ensure the		1
UIVIS	ion of Health Care Easility			· · · · · · · · · · · · · · · · · · ·	ont.	ı

Duplicate

LW9W11

STATE FORM

if continuation sheet 9 of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:		SE CONSTRUCTION	X3) DATE SURVEY COMPLETED
 .	TN9002	U. WING		OTHER DE CO
IAME OF PROVIDIER OR SUPPLIFE	STREET /	DDRESS CITY	STATE, ZIP CODE	05/17/2017
ORNERSTONE VILLAGE		ERWOOD DE	RIVP	
····	JOHNSO	ON CITY, TH	37601	
(X4) ID SHMMARY STA FRUTX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL.	 טו	PROVIDER'S PLAN OF CORRECTION	
TAIS REGULATIONY ON LE	SC IDENTIFYING INFORMATION)	PRFFIX	(EAGH CORRECTIVE ACTION SHOULD I CROSS REFERENCED TO THE APPROPR	350
N 494 . O		.j	DEFICIENCY)	L. 1000
N 424 Continued From page		N 424		:¦··
, back, and looped ov	er the kick spur. Continued	-		1
Aboet Action Link Acid	O INO BOTH STEED WOO Avec the	į	1	
whereful all side, cro	ISSECT ID hack, and looked	;		ł
ANOLUNG KICK SDIT. (Continued interview confirmed	1	1	.
the lap belt had been	n applied incorrectly.	1		[
N 601 1200 no ne necessa	N 479 - 1	1		ľ
N 601 1200-08-06-,06(1)(a) Hasic Services	N 601	deficient practice will not recur; i.e.	cont.
(1) Performance Im	DEGLES	1	What quality assurance program will	. 1
, try t shorthance (()	provement.	!	be put in place. Beginning 5/12/201	',
(a) The nursing hor	ne must ensure that there is	!!!	the NHA will begin QAPI Committee	′ 1
: Mit WitCouyG, 181CIIIIV-V	VICIO NOMATORANA	[]	meetings monthly x 6 months then	
anthioxellicit blouts	m to evaluate recident and	}	quarterly thereafter to ensure the	
and performance of	the organization.	<u> </u>	quality of care is monitored and	- 1
Į		}	complies with the standard of care.	
This Rule is not met		1	Beginning 5/12/2017 the NHA will	1
This Rule is not met Based on facility police	as evidenced by:	[}	ensure the Monitoring and Trending	,]
manufacturer's instru	ictions, medical record		Reports for Incident/Accidents,	
i ioview, observation s	And Intensions the feetiles		Infection Control, Reportable Events	,
I inved to impounding a	Drogram for the		resident ADLs are documented, care	.
management of resta	aints.	j	plans are updated with correct	
į	i	1	interventions, resident dignity	1
The findings included	:	1	staffing posted, infection control -	.]
Interview with the Med	dinal Diverse / Asso		hand hygiene - following procedure	
5/11/17 at 8:45 AM in	the conference room,	1	and not changing gloves, restraints,	
L communica ma MD and	anded Ouglik Assumes 1	- 1	answering call lights, improper	1
i meenings and made n	O (CCOtorocodeliero For		administration of drugs – mixing two Insulin medications, and incomplete	' [
restraint reductions in	the facility.		documentation by Licensed staff, &	1
	•		staffing levels. All monitoring tools	J
Interview with the facil	ity Administrator and	Ì	developed for the survey	
Taceuseu tascucal Nui	(Se (LPN) #4 on 5/19/97 at 上	1	deliciencies will be reviewed by	1
Taron time no me consen	ence room revealed the 1		Administrator prior to submitting at	
Quality Assurance (Q/	y team, including all		each QAPI Committee meetings.	1
Medical Director has in	ry other month, and the	1	Beginning 5/12/2017 at the QAPI	
солсеть. Further into	view revealed the QA team	}	meeting upon reviewing the results	ĺ
discussed the number	and type of rectorists	}	of the monitoring reports that	. 1:
	recess cycles on resolutions.		demonstrates a pattern, an Action	

Duplicate

1.W9W11

If continuation sheet it of 28

Division of Health Care Facilities FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED TN9002 B. WING. 05/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CORNERSTONE VILLAGE : 2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D PRÉFIX . (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 424 Continued From page 8 N 424 back, and looped over the kick spur. Continued observation revealed the right strap was over the wheelchair side, crossed in back, and looped over the kick spur. Continued interview confirmed the lap belt had been applied incorrectly. N 601 1200-08-06-.06(1)(a) Basic Services N 801 cont. Plan will be written by the (1) Performance Improvement. committee. Any Action Plans will be monitored by the NHA weekly until (a) The nursing home must ensure that there is resolution. Beginning 5/12/2017 the an effective, facility-wide performance NHA will conduct meetings monthly improvement program to evaluate resident care and performance of the organization. x 6 months then quarterly thereafter. The QAPI meeting will be attended by the NHA, Medical This Rule is not met as evidenced by: Director, DON, ADON, QA Nurse, Based on facility policy review, review of Risk Manager, Social Services manufacturer's instructions, medical record Manager, CDM or Dietitian, Therapy review, observation, and interview, the facility Manager, and Medical Records failed to implement a program for the Manager. Members will attend management of restraints. meetings 100% of the time with any absences approved prior to meeting The findings included: and that all reports and monitoring are completed in a timely manner Interview with the Medical Director (MD) on for each meeting by all respective 5/11/17 at 8:45 AM, in the conference room, managers. Results of the QAPI confirmed the MD attended Quality Assurance meetings will be presented quarterly meetings and made no recommendations for to the governing body board restraint reductions in the facility. meeting. Interview with the facility Administrator and Licensed Practical Nurse (LPN) #1 on 5/11/17 at 4:34 PM, in the conference room, revealed the Quality Assurance (QA) team, including all disciplines, meets every other month, and the Medical Director has input with addressing concerns. Further interview revealed the QA team discussed the number and type of restraints. Division of Health Care Facilities STATE FORM

8699

LW9W11

If confinuation sheet 8 of 28

PRINTED: 06/01/2017

Continued interview revealed LPN #1 knew restraints were applied correctly by resident behavior, infection control, and information from everybody, "I monitor nurse's on floor, oversee if done correctly". Further interview with the Administrator revealed residents with restraints are discussed in the morning meeting. Interview with the facility Administrator and LPN #1 on 5/#1/17 at 5:00 PM, in the business office common area, confirmed the Quality Assurance team had not identified restraints and their use as a concern in the Quality Assurance meetings. 1200-08-06-06(2)(d)3. Basic Services (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall; 3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rulo is not met as evidenced by: Based on review deficient practice and on review of the Medical Director in the facility with the use of the restraint, Revised QAPI Plan and QAPI standardized agenda, Wright Management, and 4) monitoring looks established for May survey deficiencies - Use and Assusment	AND PI AN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIFR/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DAI	L SURVE IPLLTEO
Single Laburus S. CITY, STATE ZIP CONE GORNERSTONE VILLAGE JOHNSON CITY, TN 37601 PROPOSERS PLAN OF CORRECTION PROPERTY IN CONTY, TN 37601 Continued From page 9 Continued From page 9 Continued Interview revealed LPN #1 knew restraints are discussed in the morning meeting. Interview with the facility Administrator and LPN #1 on 5/11/17 at 5,00 PM, in the business office common area, confirmed the Quality Assurance meetings. N 615 1200-08-08-08-09(2)(d)3, Basic Services. (d) The Medical Director shall: 3. Review reports of all accidents or unusual modernic occurrency on the protriscs, identifying hazards to health and safely and recommending corrective ection to the administrator; This Rulo is not met as evidenced by: Based on roview of the Medical Director failed to coordinate medical care in the relating propriate assessment, and 4) monitoring tools established for Navessment in the grading residents on the restraint, tevised QAP Plan and QAP sunangement, and 4) monitoring tools established for Research of Neglections and June 10 tools of propriate assessment in the restraint provision of the Medical Director failed to coordinate medical care in the restraint, tevised QAP Plan and QAP sunangement, and 4) monitoring tools established for Navessment in the facility by desirating prefetched and the propriate assessment delicities.				n. Wing			
Continued From page 9 N 601 Continued From page 9 N 601 Continued interview revealed LPN #1 kinew restraints were applied correctly by resident behavior, infection control, and information from everybody." Life monitor nurse's on floor, oversee Certified Nurse Assistants, and staff, I would see if done correctly." Further interview with the Administrator revealed recting meeting. N 615 N 616 N 6	NAME OF (PROVIDER OR SUPPLIER	SYNTECA				<u> 17/201</u>
OCAJ IU PREFER SUMMARY STATEMENT OF DEPOSPORUS DEPOSPORUS PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PREFERBER RY PULL PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PREFERBER RY PULL PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PREFERBER RY PULL (EACH DEPOCENCY MUST IUE PREFERBER RY PULL (EACH DEPOCENCY MUST IUE PREFERBER RY PULL (EACH DEPOCENCY MUST IUE PREFERBER RY PULL (EACH DEPOCENCY MUST IUE PREFERBER RY PULL (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY MUST IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCENCY IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCROCY IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCROCY IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCROCY IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCROCY IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCROCY IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCROCY IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCROCY IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCROCY IUE PROVIDERS PLAN DE CORRECTION (EACH DEPOCROCY IUE PROVIDER PLAN DE CORRECTION (EACH DEPOC	GORNER	STONE VIII LAGE	2012 SH	HHWOOD D	DIME ZIP CODE		
PROVIDERS PLAN OF CORRECTION PROPERCIES PROVIDERS PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPUNCY PLAN OF CORRECTION CROSS PREFERENCY TO THE REPROPURCY PLAN OF CORRECTION CROSS PREFERENCY PROPURCY PLAN OF CORRECTION CROSS PREFERENCY P			JOHNSO	DN CDY TM	37804		
N 601 Continued From page 9 Continued interview revealed LPN #1 knew restraints were applied correctly by resident behavior, infection control, and information from everybody. "I monitor nurse's on floor, oversee Gertified Nurse Assistants, and staff, tworld see if done correctly" Further interview with the Administrator revealed residents with restraints are discussed in the morning meeting. Interview with the facility Administrator and LPN #1 on 5/11/17 at 5:00 PM, in the business office common area, confirmed the Cuality Assurance team had not identified restraints and their use as a concern in the Quality Assurance meetings. N 615 1200-08-06-06(2)(d)3. Basic Services (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the promisos, identifying hazards to health and safely and rocommending corrective ection to the administrator; This Rulo is not met as evidenced by: Dased on roview of the Medical Director review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the locality provise, and in the facility with the use of the restraint, the vised QAPI Plan and QAPI standardized agenda, Wright Management, and 4) monitoring tools established for May survey deficiencies - Use and Assessment	(X4) [D]	SUMMARY ST	ATEMENT OF DEFICIENCE	———·			.
Continued interview revealed LPN #1 knew restraints were applied correctly by resident behavior, infection control, and information from everybody, "! monitor nurso's on floor, oversee Certified Nurse Assistants, and staff, I would see if done correctly." "Further interview with the Administrator revealed residents with restraints are discussed in the morning meeting. Interview with the facility Administrator and LPN #1 on 5/11/17 at 5:00 PM, in the business office common area, confirmed the Quality Assurance toam had not identified restraints and their use as a concern in the Quality Assurance meetings. N 615 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director shall; 3. Review reports of all accidents or unusual incidents occurring on the protrises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rulo is not met as evidenced by: Based on roview of the Medical Director Agreement, medical record review, scalility policy review, observation, and interview, the facility with the use of the creatmint, the vised OAP1 Plan and QAP1 standardized agenda, wright Management, and 4) monitoring Lools established for May survey deficiencies — Use and Assessment.	IAG	RUGULATORY OR I	Y MOST DE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREHX	CROSS-REFERENCED TO THE APPL	10 13 102	COMP (XI
Continued interview revealed LPN #1 knew restraints were applied correctly by resident behavior, infection control, and information from everybody, "! monitor nurso's on floor, oversee Certified Nurse Assistants, and staff, I would see if done correctly" Further interview with the Administrator revealed residents with restraints are discussed in the morning meeting. Interview with the facility Administrator and LPN #1 on 5/11/17 at 5:00 PM, in the business office common area, confirmed the Quality Assurance team had not identified restraints and their use as a concern in the Quality Assurance meetings. N 615 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director shall; 3. Review reports of all accidents or unusual incidents occurring on the protrises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on roview of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by usuring residents and the second agreement, and 4) monitoring looks established for May survey deficiencies - Use and Assassment.	N 607 ;	Continued From pa	ige 9	N GO1	1	<u> </u>	┿┈
This Rulo is not met as evidenced by: Dased on roview of the Medical Director shall; and information from the following: 1) the outcomes of the survey 2) expectations and roce of the Medical Director shall; and safety and rocommending corrective action to the administrator; This Rulo is not met as evidenced by: Dased on roview of the Medical Director Agreement, modical record review, facility Medical Director, and interview, the facility Medical Director failed to coordinate medical care in the restriction, and interview, the facility Medical Director failed to coordinate medical care in the promisers, identifying hazards to health and safety and rocommending corrective action to the administrator; 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: 2. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: 3. Review reports of all accidents or unusual incidents occurring on the promises, identifying hazards to health and safety and rocommending corrective action to the administrator; This Rulo is not met as evidenced by: Dased on roview of the Medical Director Agreement, modical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility policy review, observation, and interview, the facility of the facility policy review, observation, and interview, the facility of the facility policy review of the facility policy review, observation, and interview, the facility policy review, possible of the facility policy review, observation, and interview, the facility policy review of the facility policy review. It is facility to the facility policy review of the facility policy review. It is facility to the facility policy review of the facility policy review. It is facility to the facility policy review. It is a promised to the facility policy review. It is a promised to the facility pol		Continued interview	V revesied I ON #4 to	,			
everybody, "I monitor nurse's on floor, oversee Certified Nurse Assistants, and staff, I would see if done correctly" Further interview with the Administrator revealed residents with restraints are discussed in the morning meeting. Interview with the facility Administrator and LPN #1 on 5/11/17 at 5:00 PM, in the business office common area, confirmed the Quality Assurance team had not identified restraints and their use as a concern in the Quality Assurance meetings. N 615 1200-08-0606(2)(d)3. Basic Services (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall; 3. Review reports of all accidents or unusual incidents occurring on the promises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Dased on roview of the Medical Director Agreement, incident record review, facility policy review, observation, and interview, the facility will the use of the restraint, Revised OAPI Plan and QAPI standardized agenda, , Weight Management, and 4) monitoring looks established for May survey deliciencies - Use and Assessment	- 1	resorants welle 300	OPER COrrective but model and	•	1		1
Certified Nurse Assistants, and staff, I would see if done correctly" Further interview with the Administrator revealed residents with restraints are discussed in the morning meeting. Interview with the facility Administrator and LPN #1 on 5/11/17 at 5:00 PM, in the business office common area, confirmed the Quality Assurance team had not identified restraints and their use as a concern in the Quality Assurance meetings. N 615 1200-08-06-06(2)(d)3. Basic Services (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the promises, identifying hazards to health and safely and recommending corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the promises, identifying hazards to health and safely and recommending corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director as outlined in the Rules and Regulations, 3) reviewed and/or revised lacility policles and procedures -testraint, leevised OAPI Plan and QAPI standardized agenda, , Weight Management, and 4) monitoring books and procedure and procedures are straint, leevised QAPI Plan and QAPI standardized agenda, , Weight Management, and 4) monitoring books are provided to coordinate medical care in the negical care.	1	ensuration, intection :	CODITOL and information to the	!			
if done correctly" Further interview with the Administrator revealed residents with restraints are discussed in the morning meeting. Interview with the facility Administrator and LPN #1 on 5/1/1/17 at 5:00 PM, in the business office common area, confirmed the Quality Assurance team had not identified restraints and their use as a concern in the Quality Assurance meetings. N 615 1200-08-0606(2)(d)3. Basic Services (2) Physician Services. (3) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the promises, identifying hazards to health and safety and recommending corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director to review the following: 1 the outcomes of the survey 2) expectations and roles of the Medical Director as outlined in the Rules and equilitions, 3) reviewed and/or revised facility policles and procedures – Restraint Management – including residents appropriate assessments, ensure safety with the use of the restraint, Revised QAPI Plan and QAPI standardized agenda, , Weight Management, and 4) monitoring tools established for May survey deliciencies - Use and Assessment		*****YPQUY,J HIJIJI	THOU DUISOU OF BASE SHOW	:	J		1
Administrator revealed residents with restraints are discussed in the morning meeting. Interview with the facility Administrator and LPN #1 on 5/41/17 at 5:00 PM, in the business office common area, confirmed the Quality Assurance team had not identified restraints and their use as a concern in the Quality Assurance meetings. N 615 1200-08-06-06(2)(d)3. Basic Services (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the promises, identifying hazards to health and safety and recommending corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director to review the following: 1) the outcomes of the survey 2) expectations and roles of the Medical Director as outlined in the Rules and Regulations, 3) reviewed and/or revised facility polices and procedures—Restraint Management—including residents appropriate assessments, ensure safety with the use of the restraint, Revised QAPI Plan and QAPI standardized agenda, , Weight Management, medical record review, facility policy review, observation, and interview, the facility policy review, presenting residents medical care in the nursing home. The		······································	SPERMINE CONTRACTOR CONTRACTOR		}		ļ
Interview with the facility Administrator and LPN #1 on 5/11/17 at 5:00 PM, in the business office common area, confirmed the Quality Assurance toam had not identified restraints and their use as a concern in the Quality Assurance meetings. N 615 1200-08-06-06(2)(d)3. Basic Services (2) Physician Services. (3) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director to review the following: 1) the outcomes of the survey 2) expectations and roles of the Medical Director as outlined in the Rules and Regulations, 3) reviewed and/or revised facility policles and procedures—Restraint Management—including residents appropriate assessments, ensure safety with the use of the restraint, Revised QAPI Plan and QAPI standardized agenda, , Wright Management, and 4) montioring tools established for those residents found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director to review the following: 1) the outcomes of the survey 2) expectations and roles of the Medical Director as outlined in the Rules and Regulations, 3) reviewed and/or revised facility policles and procedures—Restraint Management—including residents appropriate assessments, ensure safety with the use of the restraint, Revised QAPI Plan and QAPI standardized agenda, , Wright Management, and 4) montioring tools established for those residents were deficient practice: On 5/12/2017 the NHA met with the Medical Director as outlined in the Rules and Regulations, 3) reviewed and/or revised facility policles and procedures—Restraint Management, and 4) montioning tools established for May survey deliciencies—Use and Assessment		·· ·· · · · · · · · · · · · · · · · ·	PRICINAL INTERPRETATION OF THE PROPERTY OF THE				
Interviow with the facility Administrator and LPN #1 on 5/11/17 at 5:00 PM, in the business office common area, confirmed the Quality Assurance toam had not identified restraints and their use as a concern in the Quality Assurance meetings. N 615 12:00-08-0606(2)(d)3. Basic Services N 615 (2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the pretnises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Dased on roview of the Medical Director Agreement, medical record review, facility policy roview, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility versiting residents medical care in the facility residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents medical care in the facility versiting residents were in the facility versiting residents medical care in the facility versiting residents were in the facility versiting residents medical care in the facility versiting residents were in the facility versiting residents and the facility versiting residents are in the facility versiting res		recommendation teaces	VACI FARIZIANIA MIRE				ļ
common area, confirmed the Quality Assurance toam had not identified restraints and their use as a concern in the Quality Assurance meetings. N 615 1200-08-06-06(2)(d)3. Basic Services N 615 (2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the pretriises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on review of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the pushing the accomplished for those residents found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director a outlined in the Rules and Regulations, 3) reviewed and/or revised lacility policles and procedures –Restraint, levised OAPI Plan and QAPI standardized agenda, , Weight Management, and 4) monitoring looks established for May survey deliciencies - Use and Assessment		arv discussed in (ho	e morning meeting.				
common area, confirmed the Quality Assurance toam had not identified restraints and their use as a concern in the Quality Assurance meetings. N 615 1200-08-06-06(2)(d)3. Basic Services N 615 (2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the pretriises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on review of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the pushing the accomplished for those residents found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director a outlined in the Rules and Regulations, 3) reviewed and/or revised lacility policles and procedures –Restraint, levised OAPI Plan and QAPI standardized agenda, , Weight Management, and 4) monitoring looks established for May survey deliciencies - Use and Assessment	[1	nterviow with the fo	colling Automatica Con-	;			ĺ
team had not identified restraints and their use as a concern in the Quality Assurance meetings. N 615 1200-08-0606(2)(d)3. Basic Services (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall; 3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rulo is not met as evidenced by: Dased on roview of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents medical care in the facility property of the Medical Director as outlined in the Rules and Regulations, 3) reviewed and/or revised lacility policies and procedures -Restraint Management -including residents appropriate assessments, ensure safety with the use of the restraint, levised OAPI Plan and QAPI standardized agenda, , Weight Management, and 4) monitoring looks established for May survey deliciencies - Use and Assessment] 7	#1 on 5/11/17 at 5 n	O DM in the burning				!
a concern in the Quality Assurance meetings. 1200-08-06-06(2)(d)3. Basic Services (2) Physician Services. (3) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the promises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rulo is not met as evidenced by: Based on roview of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents medical care in the nursing home. The Medical Director shall: 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director as outlined in the Rules and Regulations, 3) reviewed and/or revised lacility policles and procedures -Restraint Management -including residents appropriate assessments, ensure safety with the use of the restraint, Revised OAPI Plan and QAPI standardized agenda, Weight Management, and 4) monitoring tools established for May survey deliciencies - Use and Assessment		~~'''''	HIDBC 936 () 636	: [
1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the promises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on review of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents ware.	1 7		RACI FASTIONNA ASSELLA NE	: 1			
1200-08-0606(2)(d)3. Basic Services (2) Physician Services. (3) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall; 3. Review reports of all accidents or unusual incidents occurring on the promises, identifying hazards to health and safety and rocommending corrective action to the administrator; This Rulo is not met as evidenced by: Based on roview of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by consuming residents medical care in the facility by consuming residents medical care in the facility by consuming residents medical care in the facility by consuming residents medical care in the facility by consuming residents medical care in the facility by consuming residents medical care in the facility by consuming residents medical care in the facility by consuming residents medical care in the nursing home. The accomplished for those residents found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director to review the following: 1) the outcomes of the survey 2) expectations and roles of the survey 2) expectations and	ة أ	concern in the Qu	ality Assurance meetings	, !			
(2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall; 3. Review reports of all accidents or unusual incidents occurring on the promises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on roview of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents record review and procedures. Less than the success of the survey 2) expectations and roles of the Medical Director as outlined in the Rules and Regulations, 3) reviewed and/or revised lacility policies and procedures—Restraint Management—including residents appropriate assessments, ensure safety with the use of the restraint, Revised QAPI Plan and QAPI standardized agenda, , Wright Management, and 4) monitoring tools established for May survey deliciencies—Use and Assessment	I					.]	
found to have been affected by the deficient practice: On 5/12/2017 the NHA met with the Medical Director shall; 3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on roview of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents medical care in the nursing home. The deficient practice: On 5/12/2017 the NHA met with the Medical Director to review the following: 1) the outcomes of the survey 2) expectations and roles of the Medical Director as outlined in the Rules and Regulations, 3) reviewed and/or revised lacility policles and procedures -Restraint Management -including residents appropriate assessments, ensure safety with the use of the restraint, Revised QAPI Plan and QAPI standardized agenda, , Weight Management, and 4) monitoring tools established for May survey deliciencies - Use and Assessment	- 1			N 615	1. What corrective action (s) wi	li be	6/15
(d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rulo is not met as evidenced by: Based on roview of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by observation are residents medical care in the facility by observation are residents medical care deficient practice: On 5/12/2017 the NHA met with the Medical Director to review the following: 1) the outcomes of the survey 2) expectations and roles of the Medical Director as outlined in the Rules and Regulations, 3) reviewed and/or revised lacility policies and procedures – Restraint Management – including residents appropriate assessments, ensure safety with the use of the restraint, Revised OAPI Plan and QAPI standardized agenda, Weight Management, and 4) monitoring tools established for May survey deliciencies – Use and Assessment	[(2) Physician Servic	es.	· [accomplished for those residen	ls	97 (5/
Medical Director shall; 3. Review reports of all accidents or unusual incidents occurring on the promises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rulo is not met as evidenced by: Based on roview of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility policy in the facility by observation and interview was all the nusual survey and survey and survey and survey deliciencies - Use and Assessment including residents appropriate assessments, ensure safety with the use of the restraint, Revised OAPI Plan and QAPI standardized agenda, Weight Management, and 4) monitoring tools established for May survey deliciencies - Use and Assessment		-	i	1	deficient practice.	the /	
Medical Director shall; 3. Review reports of all accidents or unusual incidents occurring on the promises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on roview of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility policy in the facility by ensuring residents were in the facility by ensuring residents were. Medical Director to review the following: 1) the outcomes of the survey 2) expectations and roles of the Medical Director as outlined in the Rules and Regulations, 3) reviewed and/or revised facility policies and procedures –Restraint Management –including residents appropriate assessments, ensure safety with the use of the restraint, Revised OAPI Plan and QAPI standardized agenda, Weight Management, and 4) monitoring Loois established for May survey deliciencies - Use and Assessment	(C	i) The Medical Dip	ector shall be responsible for				
3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rulo is not met as evidenced by: Based on roview of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility policy in the facility by ensuring residents medical care in the facility by ensuring residents medical care in the facility by ensuring residents medical care.		colcal cale it i	NO DUNDO BORGO TA. (Ī	Medical Director to contour the	r ene:	
incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on review of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Management, and 4) monitoring tools established for May survey deliciencies - Use and Assessment.	'''	word Directly sha	n;	1	following: 1) the outcomes of the		
This Rule is not met as evidenced by: Dased on review of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the Rules and Regulations, 3) reviewed and/or revised lacility policles and procedures—Restraint Management—including residents appropriate assessments, ensure safety with the use of the restraint, Revised QAPI Plan and QAPI standardized agenda, , Weight Management, and 4) monitoring Loois established for May survey deliciencies—Use and Assessment	3,	Review renorts of	if all special and	- 1	Survey 2) expectations and roles	ν.; 	
the Rules and Regulations, 3) reviewed and/or revised facility policles and procedures—Restraint Management—including residents appropriate assessments, ensure safety with the use of the restraint, Revised QAPI Plan and QAPI standardized agenda, , Weight Management, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents were.	, ,,,	MINICHES DETERMAN	D IDA tibusanini. I I ila i	J	the Medical Director as outlined	in	
This Rule is not met as evidenced by: Dased on review of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents were.	1 ***	aciando to tresitii) SiliC	I Safety and moorementing 1	1	the Rules and Regulations, 3)	"'	
Policies and procedures –Restraint Management –including residents appropriate assessments, ensure safety with the use of the restraint, Revised QAPI Plan and QAPI Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents were.	j ido	prective action to th	e administrator:	1	reviewed and/or revised facility	}	
Management –including residents appropriate assessments, ensure safety with the use of the restraint, Revised QAPI Plan and QAPI	1		· · · · · · · · · · · · · · · · · · ·		policies and procedures –Restrai	nt [
This Rule is not met as evidenced by: Based on review of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents were.	1				Management -including resident	ts	
This Rule is not met as evidenced by: Based on review of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents were.			[арргоргіate assessments, ensuro	: 1	
Based on roview of the Medical Director Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents were	175	is Rule is not		1	 safely with the use of the restrain 	nt,	
review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents were	Ba	m ruio is not met ; ised on roview et 45	As evidenced by:		Revised QAPI Plan and QAPI		
Medical Director failed to coordinate medical care in the facility by ensuring residents were	Λα	reement tooley of al	Proof region 5	1	slandardized agenda, , Weight	ĺ	
Medical Director failed to coordinate medical care in the facility by ensuring residents were	rev	/iew, observation a	nd intensions the facility policy		Management, and 4) monitoring	: 1	
With 190 190 (1) STITIO regidente week	1 1970	ANGOL WILD	I fo coordinate and a last a last		 Look established for May survey 	i	
1	(***)	THE TRUMENTY OF CHIEFING	IIII ragidanta wasa			nt J	
Appropriately assessed for the one of real state of the s	1 (2)	Propriately assasses	d for the upo of year, it is	ĺ			
) and which to charle residents were case with the life in the control of the con	∫ and	d failed to ensure re	sidents were safe with the	1	orders/Consent/Monitoring of Us	se .	
of Figure 1 of Restraints, Restraint assessment cont.	of f-lealth	Care Facilities			or Kestraints, Restraint assessmen	nt cont	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TPLE CONSTRUCTION NG:	COV (CX)	E SURV
	TN9002	B. WING			
NAME OF PROVIDER OR SUPPLIER	STREETA	ADDRESS CIV	Y, STATE, ZIP CODE	1 05	/17/20
CORNERSTONE VILLAGE	2012 SI	ERWOOD I	DRIVE	• • • • • •	,
——: <i>—</i> ——.	JOHNS	ON CITY, T	V 37601		
(X4) ID SUMMARY STA		עו		<u> </u>	
	MUST BE PRECEDED BY FULL SCIDENT'S YING INFORMATION)	PREEX TAG	PROVIDER'S PLAN OF CORRECT (FACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	Dinac	co
N 601 Continued From pa	ge 9	N 601			ļ., ,_
Continued interview	TOWNSOLD LONGER	1 14 007			}
Ligariallia well bibli	IGA CARRANIL. L				1
r ~~~vosvior, integrandir r	CONTROL CONTRACTOR - 12	!			
1 - **** JOSUV. [10]	HITCOO AS STAR	:]
7 COMMO MUISIS ASSI	SIMPLE CIPIAL ALACE L	i	1		
			1		ļ
are discussed in tho	ed residents with restraints	:	İ		
•	·	t	1		
Interview with the fac	cility Administrator and LPN				l
		:			
		i ;			
	med the Quality Assurance ed restraints and their use as lity Assurance meetings.	! :		,	
1		!	I	1	
N 615 1200-08-0606(2)(d)	3. Basic Services	N 615	and evaluation Posiders pro-		
(2) Physician Service			and evaluation, Resident Rights for ADI documentation per care	or cont.	
CA LINGUIGHT SCIAICS	98, · ·		L PROMOUTILION INTO LA AUGUSTA	-	
(d) The Medical Dire	ctor shall be responsible for		I work the control - hand known	1	
T *** *********** OED O JI III	H DUTCHNIE brown 10.		I TOWNS DIOCCURE and not	i	
Medical Director shall	:		COMPLETE RIOVES, anguaring of the	ļ	
3. Review reports as	-n	ļ	PONCY IMPRONE Schoolsteleans		
I Walderita Olicilli fill Mi	all accidents or unusual the premises, identifying		"" MO" UNKERT INCO (nonlin	I	
Communication (Charles)	Sataty and vacaning to 1	ļ	medications, current & appropriat interventions on care plans,	e l'	•
corrective action to the	administrator:	}	millotte documentarian to	1	
		ł	Licensed Stall, & Staffing Involved	, [
1		1	menical on eclar containatest accept	- 1	
1		}	who the appropriate use of restanta-	ıs J	
This Rule is not met a	S ettidorood by:		**************************************		
L Delaga Oll Taylow Of the	Madical Dissert-	- 1	"" [*] ",5 # # 100, # # 33, # 14, # 55 and lead	8	
r restoument, medical m	COIO rovious Daniel - e	I	A ANICH CHE MING MONTHOUSE	-	
TOTAL PROPERTY OF THE STREET	O Difference the feature.		ADON, and NEW Risk Manager on	1	
Lancatora Director Billion	in convincto martine.	};	5/17/17. Any interventions such as assessment for implementation,	- 1	
I are error resountly DA GIASIMIN	O fosidonte word		assessment for reduction, continued		
and failed to ensure see	for the use of restraints, lidents were safe with the	\rightarrow	use, safety of the apparatus, Care	ļ	
- Constitution	nuerios were safe with the	1	apparatus, Care	cont.	
of Health Care Facilities ORM	——————————————————————————————————————	ſ			



If continuation sheet 10 of 28

	STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	(X2) MUILTIN	T~764 P	0007/001	:
	ANDIPLA	N OF CORRECTION	IDENTIFICATION NUMBER:				e survey Pleteo
		, , , , , , , , , , , , , , , , , , ,	TN9002	B. WING_		or.	47/0047
	NAME OF	PROVIDER OR SUPPLIER	STREET AS	Ingree onv	CTATE DA CORO	1 05/	17/2017
		RSTONE VILLAGE					
	~		ОЗИНОС	N CITY, TN	37601		
ļ	(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	םן	PROVIDER'S PLAN OF CORRE	CTION	(X5)
	TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETE
ı	N 801	Continued From pa	ge 9	N 601		···	
ľ		Continued interview	revealed LPN #1 knew lied correctly by resident			ļ	
l		j restraints were app.	lied correctly by resident	• !			
		everybody. "l mor	applied correctly by resident on control, and information from monitor nurse's on floor, oversee Assistants, and staff, I would see". Further interview with the vealed residents with restraints the morning meeting.			1	
		Certified Nurse Ass	istants, and staff. I would see	B. WING B. WING STREET ADDRESS, CITY, STATE, DP CC 2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601 JIL PREFIX (EACH ON) TAG CROSS N 601 WITH TAG CROSS N 601 WITH TAG CROSS N 615 Plan upo applicati interven impleme tinterven tinterven tinterven tinterven tinterven tinterven tinterven tinterven tinterven tinterve			[
		REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 Continued interview revealed LPN #1 knew restraints were applied correctly by resident behavior, infection control, and information from the everybody, "I monitor nurse's on floor, over Certified Nurse Assistants, and staff, I would if done correctly" Further interview with the Administrator revealed residents with restrain are discussed in the morning meeting. Interview with the facility Administrator and LF on 5/11/17 at 5:00 PM, in the business officement area, confirmed the Quality Assurance meetings. In the Cuality Assurance meetings. Interview in the Quality Assurance meetings.			,]
	;	Administrator revea	led residents with restraints	•			j
		are discussed in life	s morrang tuesaug-	ŧ			
		Interview with the fa	cility Administrator and LPN	! '			ĺ
		! #1 on 5/11/17 at 5;0	0 PM, in the business office		•		j
		team had not identif	rmed the Quality Assurance				
		a concern in the Qu	ality Assurance meetings.			j	
	N 615	1200-08-0606(2)(d)3. Basic Services	N 615	Plan update, appropriate	Cont.	
		(2) Physician Service	es.		application, and any other intervention that was needed to implemented on this date by the		
	•	(d) The Medical Dire	ector shall be responsible for		Medical Director. On 5/17/17 t		
	- 1	the medical care in t Medical Director sha	he nursing home. The		Medical Director was notified o		
		medical Difactor alia	łNi		survey findings by the Adminis	trator.	
	- 1	3. Review reports of	of all accidents or unusual	ļ	2. How you will identify other residents having the potential	•• •-	
	.	incidents occurring o	n the premises, identifying	i	affected by the same deficient		
		corrective action to t	d safety and recommending	j	practice and what corrective a		
	1		is during participation of		will be taken.	İ	
			,	ł	Beginning 5/17/2017, as a		
	ĺ				Systematic Approach, the Administrator, DON and Medic	al le	
		This Rule is not met	as evidenced by	j	Director will review monthly th		
	j	Based on review of t	ne Medical Director		audit materials from the auditi		

Division of Health Care Facilities STATE FORM

128

LW9W11

schedule for the adherence to the facility's policies and procedures for

restraint usage and application,

Weight Management and
 Notification of resident changes...

if continuation sheet 10 of 28

cont.



Agreement, medical record review, facility policy review, observation, and interview, the facility

Medical Director falled to coordinate medical care

in the facility by ensuring residents were appropriately assessed for the use of restraints,

and failed to ensure residents were safe with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	PLE CONSTRUCTION G:	(X3) DATE COMP	SURVE LETED	
	TN9002	8. WING		05/1	7/201	
IAME OF PROVIDER OR SUPPLIE	<u>R</u> STREET AI	ODRESS, CITY	, STATE ZIP CODE	, , , ,		
ORNERSTONE VILLAGE	2012 SHI	RWOOD D	RIVE			
Prefix : (Each Deficien	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	JLD BE	GOM D/	
N 601 Continued From	nage 9	N 601		<u>_</u>		
restraints were ap behavior, infection everybody, "I m Certified Nurse As if done correctly Administrator reveare discussed in the way on 5/11/17 at 5 common area, co team had not iden a concern in the C	w revealed LPN #1 knew plied correctly by resident a control, and information from positor nurse's on floor, oversee esistants, and staff, I would see "Further interview with the ealed residents with restraints the morning meeting." facility Administrator and LPN 100 PM, in the business office offirmed the Quality Assurance tified restraints and their use as quality Assurance meetings.					
Medical care in Medical Director s 3. Review report incidents occurring	vices. Irrector shall be responsible for the nursing home. The hall: of all accidents or unusual on the premises, identifying and safety and recommending	N 615	3. What measures will be put in place or what systematic changes will you make to ensure that the defident practice does not recur: Beginning 5/12/2017 and up to 5/17/17 the Administrator & DON reviewed all monitoring tools created for restraints, ADL documentation of weights and for consumption, infection control concerns, employee competencies checks for restraints, Employee personnel files, answering call ligh mixing drugs (insulins), care plans,	od 5	-	

Agreement, medical record review, facility policy review, observation, and interview, the facility Medical Director failed to coordinate medical care in the facility by ensuring residents were appropriately assessed for the use of restraints, and failed to ensure residents were safe with the

often as needed. Beginning 5/17/17 the NHA will educate the MD Medical Director along with the NP on the restraint policy and procedure. ¹Beginning 5/12/2017 the

cont.



LW9W11

STATEMENT OF DEFICE AND PLAN OF CORREC	ENCIES TION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	Surve Leted
		TN9002	B. WING	-	05/1	7/201
IAME OF PROVIDER O	r supplier	STREET AL	ORESS, Cary,	STAYE, ZIP CODE		
ernerstone v	በ <i>የ ል</i> ፎድ		RWOOD DE			
			N CITY, TN			
PREFIX : (EAC)	A DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT , (EACH CORRECTIVE ACTION SHOU OROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X COMP DA
N 801 Continue	d From pa	ge 9	N 601			
restraints behavior everyboo Certified if done c Administ are disct interview #1 on 5/- common team had	s were apple, infection of ly, "! more Assignment of Murse Assignment of the light of the lig	r revealed LPN #1 knew led correctly by resident control, and information from hitor nurse's on floor, oversee istants, and staff, I would see . Further interview with the led residents with restraints a morning meeting. actility Administrator and LPN 100 PM, in the business office irmed the Quality Assurance fied restraints and their use as ality Assurance meetings.				
(2) Physical (2) Physical (2) The the medical (2) Revision (2) Agreement (2) Physical (2) Physic	Medical Director shape is not me action to review of the medical beervation, Director fall	rector shall be responsible for the nursing home. The	N 615	Administrator will ensure the Medical Director is informed and reviewing any State reportable of unusual occurrences, unusual deaths, restraints usage, standards of care issues such as excessive weight loss or gain, restraint reduction program as evident by signature on the document. 4. How does the corrective action will be monitored to ensure the deficient practice will not recur; What quality assurance program will be put in place. Beginning 5/12/17 the NHA will monitor the Medical Director's effectiveness in reviewing and monitoring quality of care i.e. weights, restraints monthly x 6 months and provide an oral reportant.	her 1(s) .e.	•

Division of Health Care Facilities STATE FORM

LW9W11

If continuation sheat 10 of 28



Ut	5-16-11	19:19 FROM-			T-764	P0010/0010	N F_070
	STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:	(X3) DATE	
-			TN9002 .	B. WING		05/:	17/2017
	NAME OF	PROVIDER OR SUPPLIER	STREET AL	DORESS, CITY,	STATE, ZIP CODE		
	GORNE	RSTONE VILLAGE	2012 SH)	RWOOD DI N CITY, TN	RIVE		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies I Must be preceded by Full SC Identifying Information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION 9 CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
	N 601	Continued From pa	ge 9	N 601			
	, Nais	restraints were app behavior, infection of everybody, "I more Certified Nurse Assif done correctly" Administrator reveal are discussed in the Interview with the farm 1 on 5/11/17 at 5:0 common area, confideam had not identifications.	icility Administrator and LPN 10 PM, in the business office Irmed the Quality Assurance fied restraints and their use as allty Assurance meetings.				
***		the medical care in Medical Director shall a Review reports incidents occurring a	ces. rector shall be responsible for the nursing home. The all: of all accidents or unusual on the premises, identifying and recommending	N 615	in the QAPI meetings and he of the QAPI and quality of causisues. The NHA will monitor Medical Director's QAPI part and attendance and report a issues to the Governing Bod NHA will ensure the Medicals fulfilling all requirements in her contract.	are r the ticipation any ly. The	nt.

in the facility by ensuring residents were appropriately assessed for the use of restraints, and failed to ensure residents were safe with the Division of Health Care Facilities

STATE FORM

This Rule is not met as evidenced by:
Based on review of the Medical Director
Agreement, medical record review, facility policy
review, observation, and interview, the facility

Medical Director failed to coordinate medical care

19

LW9W11

If continuation sheet 10 of 28



PRINTED: 06/01/2017 FORM APPROVED

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED TN9002 B. WING. 05/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CORNERSTONE VILLAGE 2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRĚFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 615 Continued From page 10 N 615 use of restraints. The findings included: Review of the Medical Director Agreement dated August, 2013 and amended on 8/15/15 revealed "...Medical Director shall...Recommend policies and procedures designed to achieve and sustain the highest standards of professional competence...On a monthly basis, review incidents and accidents that occur on the premises of the center to identify hazards to health and safety...Participate in developing written policies governing the medical, nursing, and related health services provided in the Facility..." Interview with the Medical Director (MD) on 5/11/17 at 8:45 AM, in the conference room, confirmed the MD was aware Resident #56 had slid under the soft belt restraint; the resident is "very active without safety awareness." Continued interview confirmed the MD had made no recommendations for restraint reductions in the facility, "was helping with fall risk, numerous falls, studies show restraints don't help with falls". Continued interview confirmed Nursing helps determine the use of restraints and Resident #56 was at risk for serious harm, injury or death due to his attempts to crawl out of the restraint. N 682 1200-08-06-.06(4)(f) Basic Services N 682 1. What corrective action (s) will be 6/15/17 accomplished for those residents (4) Nursing Services. found to have been affected by the (f) The facility must ensure that an appropriate deficient practice: Residents # 56 had his Care Plan individualized plan of care is prepared for each resident with input from appropriate disciplines, revised on 5/10/17 by the Risk the resident and/or the resident 's family or the Manager to reflect his current or continued need for a restraint due to cont. Division of Health Care Facilities STATE FORM пява LW9W11

If continuation sheet 11 of 28

PRINTED: 06/01/2017 FORM APPROVED

SIATEME	1 of Health Care Fac NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/ÇLIA				APPROV
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	
			A. BUILDING	3:	COMP	LETED
		TN9002	8. WING	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	05/4	7/2017
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY.	STATE, ZIP CODE		112011
ORNER	RSTONE VILLAGE		ERWOOD DI			
	 	JOHNSO	Ñ CITY, TŃ	37601		
(X4) ID PREFIX	i (Each Deficienc	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	: 10	PROVIDER'S PLAN OF CORRECT	TON .	(X5)
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR	JLD BE OPRIATE	(X5) COMPLE DATE
		<u> </u>	<u> </u>	DEFICIENCY)	*******	
N 682	Continued From pa	age 11	N 682	spasticity and involuntary	cont.	i
	resident 's represe	entative.	i	movements/shakes related to a		
ĺ			:	traumatic brain injury along with		
İ			1	restraint monitor and to obtain	į	
- 1	This Rule is not m	et as evidenced by:		quarterly restraint assessment. A evaluation for a less restrictive	An .	
	Based on medical	record review, observation,		restraint was completed on 5/11,	Arr	
	plan to include the	acility failed to revise a care need to do a restraint	ì	to one on one monitoring and the	/1/	
	assessment quarte	rly, and failed to include	ŧ.	reduced to a pelvic slider belt and	₩11 4	
	monitoring the use	of a soft waist belt for 2 (#56,	İ	care plan was updated on 5/12/1	7	
ľ	#145) residents.	Wallet 2012 101 2 (1700,	:	On 6/6/17 a restraint assessment		
	7m. g		•	'was completed and restraint	i	
- 1	The findings includ	ed;		discontinued and resident placed	in	
	Madical record		:	Rocking King wheelchair for mobi	lity	
1	admitted to the feet	ew revealed Resident #56 was	į.	and safety.	·	
	On 6/6/16 with diag	lity on 1/20/15 and readmitted noses including Traumatic		Resident # 145 had her Care Plan		
	Brain Injury, Epilep	sy, Dementia with Behavior		revised on 5/12/17 by the Risk		
1	Disturbance, Pseud	lobulbar Affect, and		Manager to reflect her need for a	;	
	Generalized Anxiet	y Disorder.		restraint related to multiple falls	}	
- 1	Billian Brown a second	•		along with restraint monitoring.		
	detect 4/7/48 revised	ew of a Physician's Order		Resident was discharged from fact on 5/17/17.	ility	
- 1	alaming celf-rologo	ed "D/C [Discontinue] se belt.M Apply soft belt		MD notified of both residents' ne	- 0	
	restraint for hy thist	ory] of falls, poor safety		for continued restraint application	ea	
- 1	awareness"	oral or idio, book safety		for safety related to falls or safety	'	
				related to spasticity on 5/12/17.		
	Medical record review	ew of the Care Plan reviewed		2. How you will identify other		
I '	on 2/2//1/ revealed	"USe of restraints r/t		residents having the potential to	be '	
	[related to] decrease	ed safety awareness; soft belt		affected by the same deficient		
[]	Pre-Restroining Ap ID	w/c [wheelchair]Complete	-	practice and what corrective action	ות תו	
	check a fevery) 30 r	essmentApply restraint and nin[minutes] and release q		will be taken.	.	
l li	[every] 2 h [hours] fo	or toileting and	ļ	On 5/12/17 the DON, ADON and		
];	repositioning"	and		MDS Coordinator reviewed all other	er İ	
1	•			residents in the facility that had an	y	
- [9	Observation on 5/9/	17 at 2:00 PM, revealed the	i	type of restraint application		
	resident in a high ba	ck wheelchair in the common		Including reviewing their Care Plan		
i	area on the upper fl	oor. Continued observation		and revised as needed to ensure a	n j	
] !	revealed, on approa	ch to the Nursing Station,		component of restraints		
5	arrother resident pol alth Care Facilities	nted at Resident #56.		management are reflected on thei	r cont.	

STATE FORM

6899

LW9W11

If continuation sheet 12 of 28

<u>Division of Health Care Facilities</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED TN9002 05/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CORNERSTONE VILLAGE 2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 682 Continued From page 12 care plan including the quarterly cont. N 682 review for removal or the continued Continued observation revealed Resident #56 need for a restraint, correct type was sliding down in the wheelchair with his feet and application, and reduction up on another chair in front of him. Continued observation revealed a soft waist restraint was on i attempts. the resident, sliding up towards the resident's One on one teachable moment with neck, with the restraint straps noted to be down the two Care Plan Coordinators was between the sides of the wheelchair, crossed conducted on 5/17/17 by the NHA to behind the resident, and looped over the kick review the importance of having spurs. Licensed Practical Nurse #1 (LPN) was accurate care plans to ensure proper standing at the medication cart on the other side care is provided by staff. of the nursing station and came to assist 3. What measures will be put in Resident #56 when summoned. place or what systematic changes will you make to ensure that the Observation on 5/9/17 at 5:50 PM, revealed deficient practice does not recur: :Resident #56 seated in a high back wheelchair in One on one teachable moment with the common area on the upper floor with the soft the two Care Plan Coordinators was belt restraint in place. conducted on 5/17/17 by the NHA Observation of the resident on 5/10/17 at 2:25 to review the importance of having PM, revealed the resident seated in a high back accurate care plans to ensure proper wheelchair with a soft belt restraint in place in the care is provided by staff. common area. On 5/12/17 the Administrator and DON reviewed the restraint Interview with Registered Nurse #2 (RN) on management policy and procedures 5/11/17 at 5:55 PM in the MDS office confirmed for needed revision but none was the care plan had not been revised to include needed but supportive forms were need to do restraint reduction assessment :updated. quarteriy. A systematic approach will be to Medical record review revealed Resident #145 have any resident that is assessed was admitted to the facility on 11/18/16 with for any type of restraint will be to diagnoses including Altered Mental Status, have the residents Care Plan Urinary Tract Infection, Dementia, and updated properly by the Risk Hypertension. Manager to reflect the need for the restraint type, monitoring, restraint Medical record review of a physician's order dated 3/28/17 revealed "May use soft waist belt reduction attempts and correct while up in wheel chair,.." application of the apparatus. The DON, Assistant Director of Medical record review of the current Care Plan Nursing and NEW Risk Manager reviewed on 2/24/17 revealed "...Risk for falls r/t cont. Division of Health Care Facilities STATE FORM

521/571 d

0868

LW9W11

If continuation sheet 13 of 28

	STATEMEN	TOT MEALTH CATE FACE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3:	(X3) DATE	SURVEY LETED
			TN9002	B. WING_		05/1	7/2017
	NAME OF	PROVIDER OR SUPPLIER	STREET AT	DDRESS, CMY,	STAYE, ZIP CODE		***
.	-CORNER	RSTONE VILLAGE	2012 SHE	RWOOD D	RIVE		
Í	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	N CITY, TN			
	PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	nee !	(X5) COMPLETE DATE
1	N 682	Continued From pa	ge 12	N 682	were in-serviced on 5/17/17 by t	he cont	
1		Continued observat	ion revealed Resident #56	:	NHA on the requirement of having	ng: .	
	ļ	was sliding down in	the wheelchair with his feet	:	residents care plan revised on a	Ĭ	
	}	l up on another chair	in front of him. Continued	·	quarterly basis to reflect the		
	i	the resident cliding	d a soft waist restraint was on up towards the resident's	ļ	restraint assessment for reductio	n, !	
		neck, with the restra	aint straps noted to be down	:	monitoring, continued usage, and		i
1		perween the sides o	of the wheelchair, crossed	i	application. An audit was put in	1	
1		· penind the resident,	and looped over the kick	<u> </u>	place by the NHA to ensure that	the	
1		spurs. Licensed Pra	actical Nurse #1 (LPN) was	i	Care Plans have been updated wit		j
1		of the nursing station	ication cart on the other side n and came to assist	j	the need for the restraint.	i	i
١	}	Resident #56 when	summoned.		monitoring, continued use,	ĺ	
1	ļ				assessment for reduction. This ar	Jdit	•
Ì	!	Coservation on 5/9/	17 at 5:50 PM, revealed		Is to be done by the DON, Risk	, }	
١	ŀ	the common area or	in a high back wheelchair in the upper floor with the soft	Ì	Manager, Unit Manager, and/or i	RN)	
1		belt restraint in place	e.	}	Supervisors each shift. The goal of	f	
1	- 1			}	the audit will be 100%	J	ĵ
1		Observation of the re	esident on 5/10/17 at 2:25		compliance. If the goal is not mei	<u>.</u>	
1		Tivi, revealed the res	sident seated in a high back If belt restraint in place in the		then the identified staff member	- 1	
ı		common area.	ar per resulation place in the		who is not meeting the goal will be	_]	<u> </u>
ı					re-educated. Continued failure to	`	
		Interview with Regist	tered Nurse #2 (RN) on		comply with the goal by the	l	1
ŀ	1	the care plan had no	n the MDS office confirmed t been revised to include	•	identified employee will result in		
ı	1	need to do restraint	reduction assessment		progressive disciplinary action, 4	ļ	ŀ
ı	- 1	quarteny.			How does the corrective action(s)		
1	1.	Medical record review	w revealed Resident #145		Will be monitored to ensure the		
Ī	1	was admitted to the t	facility on 11/18/16 with		deficient practice will not recur; i.e	e.	- 1
ĺ	1	Urinary Tract Infectio	Altered Mental Status,		what quality assurance program	·	
ĺ		Hypertension.	in, Dontonea, and		will be put in place.		
ĺ	1	Medical record review	w of a physician's order		Beginning 6/1/17 the NHA or DON		
	1	dated 3/28/17 revealed	ed "May use soft waist belt	ľ	: Will review all restraint care plans	1	1
],	while up in wheel cha	ir"		: and new admissions' care plans her]
			-		month for a period of 3 months to		1
		Medical record review	of the current Care Plan		ensure care plans are accurate and	1	Ī
P	islon of Hea	alth Care Facilities	revealed "Risk for falls r/t		timely for restraint information:	cont.	
	ATE FORM					 •	·



LW9W11

If continuation sheet 13 of 28

1	DIVISIO	<u>n'or Health Care Faci</u>	lities			FORM	M APPROVED
	STATEME AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	PLE CONSTRUCTION IG:		E SURVEY PLETED
			TN9002	B. WING_			
	NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS CITY	/, STATE, ZIP CODE		17/2017
		rstone VILLAGE	2012 SH 	ERWOOD D	PRIVE		
	(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	III O AE	(X5) COMPLETE DATE
		was sliding down in up on another chair observation reveale the resident, sliding neck, with the restrabetween the sides obehind the resident, spurs. Licensed Prastanding at the med of the nursing station Resident #56 when Observation on 5/9/Resident #56 seated the common area or belt restraint in place. Observation of the reswheelchair with a socommon area. Interview with Regist 5/11/17 at 5:55 PM in the care plan had not need to do restraint requarterly. Medical record review was admitted to the fidiagnoses including A Urinary Tract Infection Hypertension. Medical record review dated 3/28/17 revealed while up in wheel chair with a social diagnoses including A Urinary Tract infection Hypertension.	the wheelchair with his feet in front of him. Continued d a soft waist restraint was on up towards the resident's aint straps noted to be down of the wheelchair, crossed and looped over the kick actical Nurse #1 (LPN) was ication cart on the other side in and came to assist summoned. 17 at 5:50 PM, revealed in a high back wheelchair in the upper floor with the soft in a high back wheelchair in the upper floor with the soft is ident seated in a high back if belt restraint in place in the interest Nurse #2 (RN) on the MDS office confirmed it been revised to include reduction assessment were vised Resident #145 active on 11/18/16 with Altered Mental Status, in, Dementia, and wo f a physician's order and "May use soft waist belt ir"	N 682	updated quarterly, assessed for continued use, monitoring and application of the correct restrative. Beginning May, 2017, the DON report monitoring outcomes of planning of restraint manageme auditing to the quarterly QAPI Committee meetings. The Administrator will report to the Governing Body concerning audites to a quarterly basis beginning 6/21/2017	will care ent	
Div	islan of Hes	By Com Englisher	evealed "Risk for falls r/t	_			ľ

Duplicate

if continuation sheet 13 of 28

STATE FORM

LW9W11

Division	n of Health Care Fac				FORM	APPROVED
AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	SURVEY
1		IDENTIFICATION NUMBER:	A. BUILDIN	G:		PLETED
			1		}	
		TN9002	B. WING_		\	1710047
NAME OF	PROVIDER OR SUPPLIER	STDECT A			U5/	17/20 <u>17</u>
		41NCC17		, STATE, ZIP CODE	_	
CORNE	RSTONE VILLAGE		ERWOOD D			
(X4) ID	SI INTERNACION STO	YEMENT OF DEFICIENCIES	N CITY, TN			
PREFIX TAG	I (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV	n re	(X5) COMPLETE
<u> </u>		<u> </u>	į	DEFICIENCY)	TRIAIE	DAYE
N 682	Continued From pa		N 682		 .	<u> </u>
	[related to] noted co	onfusion and need for				!
`	extensive assist wit	th transfers and	-	1		!
Ì	ambulationsoft w	sist belt while in wheel chair	<u> </u>			!
	Start date: 03/28/17	" Continued review of the	i			į
]	the manifering of the	evealed no documentation for	•			:
]	the monitoring of th	e soft watst belt.	!	1		•
!	! Observation on 5/4/	0/17 at 1:50 PM revealed the	į	1		í
	resident seated in a	wheelchair, in the hallway.	1			[
	with a soft waist bel	t restraint in place	•			Ì
	William Colt Walde Del	creataint in piace.	:			
	Interview with Regis	stered Nurse (RN) #2, on				
	ויטיים at יויטיים Alv	1. in the MDS office, confirmed				
}	one care pian was n	Of revised to include the need.				
· }	. TO THE SOR Walst be	It restraint to be checked	ļ			
	every 30 minutes ar	id released evenus hours or	İ		•	
	are resear to no 9 t68	traint reduction review every				
	3 months.	•		l ⁱⁿ		
N con	4000 40 40		!			
N 698	1200-08-0606(4)(v) Basic Services	N 698	1. What corrective action (s) will be	.	6/15/17
}				accomplished for those residents	•	-, 25, 17
1	(4) Nursing Service	S.		found to have been affected by the	.	
1	(v) Popidont-1	-L. 4 94		deficient practice:	•	
}	(v) residents well	ghts shall be taken and		Resident #51 expired on 3/28/2017		
.	by a physician 's ord	onthly unless contraindicated		at 16:32 at the hospital. Resident	J	ļ
ł	p y = 1010011	10r.		# 51 is no longer a resident at this		
	This Rule is not met	as evidenced hv		facility as of 3/24/17. On 4/1/17 -	ļ	- 1
	based on review of f	acility policy medical record		5/12/17 the Administrator, DON,	[
13	review, and interview	/, the facility failed to (and Attorney did an internal]
į į	maintaiл acceptable	nutritional status, resulting in 1	i	investigation on resident #51's	ľ	i
[;	a 10.9% weight loss	for 1 resident (#51).		medical record which included]
		· · · · · · · .		Physicians orders, progress notes,	- 1	- 1
[The findings included	d:		care plans, assessments, MDS, etc.		
1.	Davida 69			along with the State Surveyors	į	ŀ
1:	Review of the facility	policy Weight Loss		deficiencies during survey. The		ł
!	revention (undated)	revealed "Weight loss	•	review was used to identify potentia	, !	
1!	ntervention will be in	plemented for those	1	issues that could affect all residents	'	İ
	conduits experiencing	ig a weight lossWeight	1	as described herein.	1	ľ
vision of Hea	olth Care Facilities				cont.	1

STATE FORM

LW9W11

If continuation sheet 14 of 28

STATEME AND PLAN	NI OF DEFICIENCIES FOR CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
<u></u>		TN9002	D. WING		05/17/2 017
NVWF OI.	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
CORNEI	RSTONE VILLAGE.		RWOOD DI		·
·		JOHNSOI	N CITY, TN	37601	
PREFIX TAG	RÉGULATORY OR LE	TEMENT OF DELICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD (FACH CORRECTIVE ACTION SHOULD CROSS-RULLERLINGED TO THE APPROVIDENCY)	DBE COMPLETE
	loss intervention is infurther weight loss a resident's nutritional Medical record review admitted to the facilitian including Fracture or ankle) of the Left An Obstructive Pulmoniand Senile Demention Resident #51 dischas 3/24/17 with diagnost Urinary Tract Infection the blood) and para 3/28/17. Medical record review Care Plan dated 2/18 less than 75% of foormealsbroken or mit monitor results Obstructive results Obstructive Pulmonian the blood and para 3/28/17. Medical record review completed by the Cere (CNA)s dated 2/18/17 Resident #51 consum to 2 meals, and 18 mit the resident consumer the res	implemented to prevent and to maintain improve the status" ew of the hospital admission revealed Resident #51 was ity on 2/18/17 with diagnoses the Calcaneal (bone in the kie, Atrial Fibrillation, Chronic ary Disease, Hard of Hearing, a. Further review revealed orged to the hospital on ses including Dehydration, on, and Septicemia (infection seed away at the hospital on w of the Baseline Admission B/17 revealed "consumes d/or fluids at most ssing teethweigh and serve for s/s dehydration & [and] report to w of the Daily Charting riffled Nurse Assistants / to 3/24/17 revealed ned 25% or less for /1 of eals had no documentation	N 698	NOTE: The comment made by the CDM that the DON and NHA were aware that weights were not being obtained is <u>UNTRUE</u> . The NHA was not aware but was made so on 3/27/17 of the issue of only two weights on Resident #51. Upon internal investigation, it was noted that this resident was only weighted on 2/21/17 and 3/17/17. The CDM nor former DON did not advise the NHA of only these two weights belied obtained. The CDM had used the hospital weight as his admission weight and he continued to use the hospital weight or later the 1 st NH weight for analysis. There was not any information relayed to the NHA in any Morning Clinical Meeting that identified that weight were not being obtained except on one occasion which was on 3/6/17 when the CDM stated that weights had no been gotten in two weeks. This was in relation to the purchase of a new scale that had arrived, then was sell back for replacement. There were two Hoyer Lift Scales in the facility. And the former D.O.N.'s former Weight C.N.A. was designated to got the weights. The NHA demanded that a Loaner wheelchair Scale be obtained that day (delivered the next morning) to do the weights on There is evidence in the new admission resident's medical record during this time frame of weights being obtained per the Floyer Lifts. Other than this one comment there	de la contraction de la contra
STATE FORM	lth Care Facilities	<u></u>			

LW0W11

If continuation sheet 15 of 28

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED TN9002 B. WING 05/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP CODE CORNERSTONE VILLAGE 2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 698 Continued From page 15 N 698 is no other mention of weights not dated 2/21/17 (3 days after admission) revealed a being obtained. cont. weight of 164.4 pounds (12.6 pound weight loss). How you will identify other Continued review of a weight dated 3/17/17 residents having the potential to be (approximately 1 month after admission) revealed affected by the same deficient Resident #51 weighed 146.2 pounds, a weight practice and what corrective action loss of 18.2 pounds or 10.9% of the resident's will be taken. All other residents in body weight. the facility had their medical record reviewed and a current weight was Medical record review of the Physician Standing obtained (except 3 hospice cases) by Orders signed by the resident's physician on 2/22/17 revealed "...:Weekly weights X [times] 4 the new weight team assigned by the NHA on 3/27/17. All weights weeks on admission, if stable then monthly..." were presented to the CDM and/or Dietitian for analysis along with MD Medical record review of "Dietitian Communication/Order Form" dated 2/22/17 notification for any nutritional revealed "...recommend multivitamin for interventions. [increased] nutrient needs..." 3. What measures will be put In place or what systematic changes Medical record review of Resident #51's care plan will you make to ensure that the dated 2/28/17 revealed "...I am at risk for altered deficient practice does not recur: nutritional status r/t [related to] assistance with all Upon being notified of missed meals and a dx [diagnosis] of dementia...I will weights on 3/27/2017, the NHA have a PO [by mouth] intake of at least 51-75% of replaced the former Weight CNA most meals by next review. Weigh me and responsible for obtaining weights monitor my weight per facility policy...Monitor my with another Weight Team C.N.A(s) daily food and fluid intake...Coordinate my due to former Weight Team C.N.A nutritional care with RD [Registered Dietitian], MD refusing to do weights as assigned by [Medical Doctor], and other disciplines as the former DON and not using the necessary..." available scales in the building. The Interview with the Certified Dietary Manager former DON failed to enforce these requests. New Weight C.N.A.(s) (CDM) and the Executive Chef on 5/12/17 at 2:35 PM, in the conference room, revealed the CDM assigned to do weights on 3/27/2017 monitored residents' weights obtained by the were in-serviced on the two Hoyer weight team. Further interview revealed the CDM Lift scales and the Loaner Scales, and used the weights to determine if he new weight scales. Beginning on recommended the RD see the resident. 5/17/17 the DON, Risk Manager, Continued interview revealed Resident #51 was &/or RN Supervisor in-serviced all not weighed for several days after admission. nursing staff (RN, LPNs, CNAs) on Further interview revealed for several weeks in cont. Division of Health Care Facilities STATE FORM

GCAB

LW9W11

If continuation sheet, 16 of 28

PRINTED: 06/01/2017 FORM APPROVED

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XV) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ____ TN9002 B. WING 05/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CHY, STATE, ZIP CODE 2012 SHERWOOD DRIVE LCORNERSTONE VILLAGE JOHNSON CITY, TN 37801 (X4) (D | SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (FACH DEFICIENCY MUST BI, PRECEDED BY PULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 698 Continued From page 16 notifying the physician when N 698 cont. resident's condition changes (decline February and March there were no weights in weight), weight management obtained by the weight team, and the CDM policy. The CDM and were inreported this to the Administrator and DON in serviced concerning the changes in morning meetings. the weight management team, Interview with the Administrator and the Director documentation of oral intake of Nursing (DON) on 5/12/17 at 3:15 PM, outside percentages of each meal, roles and of the Administrator's office, confirmed only 2 responsibilities in regards to the weights were obtained during Resident #51's stay resident's weight management and at the facility. nutritional status. Any stall missing in-servicing will not work until they Interview with Licensed Practical Nurse (LPN) #6 receive the education. Any staff who on 5/15/17 at 9:56 AM, at the downstairs nurse's fall to comply with the points of the desk, confirmed he was aware of Resident #51's in-services will be further educated poor intake and did not notify the Nurse and/or progressively disciplined. Practitioner (NP) or the physician. As a systematic process going forward, the CDM was advised by Interview with 1.PN #7 on 5/15/17 at 9:56 AM, at the NHA on 5/12/17 to never use a the downstairs nurse's desk, confirmed she was aware of Resident #51's poor intake and did not hospital weight in the future for the notify the NP or the physician. resident's admission weight since there is such a discrepancy in the Interview with Certified Occupational Therapist two facility scales. Assistant (COTA) #1 on 5/15/17 at 10:01 AM, in The MD and/or NP will be advised of the upstairs dayroom, revealed COTA#1 worked any significant weight losses as they with Resident #51 during his stay in the facility. occur so appropriate interventions Further interview revealed Resident #51 mostly can be implemented timely. The picked at his food, preferred smooth consistency, NHA also implemented a new and did better with finger foods due to his Weight Team consisting of three impaired vision. Continued Interview with COTA C.N.A.'s, the Adminitrative Assist/Pt #1 confirmed she did not report to the RD he Representative, DON, ADON, Risk wasn't cating "...that is nursing's job..." Manager, Therapy Manager, Social Services Mgr, CDM and Dietitian to Interview with NP #1 on 5/16/17 at 11:21 AM in ensure that weights are obtained the small conference room, revealed NP #1 was Limely 3/27/17. Education was in the facility Monday through Friday each week. provided to the DON, Assistant DON, Further interview revealed new admission residents were weighed weekly for 4 weeks and CDM and Dictitian on the weight. then monthly. Continued interview revealed NP management process new weight. #1 usually received reports from Nursing team meeting and weight C.N.A.'s by Division of Health Care Facilities

STATE FORM

TVV9W11

If confinuation sheet, 17 of 28

	<u>in of Health Care Fact</u>	<u>lities</u>			
AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
<u></u>		TN9002	B. WING		05/17/2017
NAME O	F PROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, S	STATE, ZIP CODE	1 447.227.2
CORNE	RSTONE VILLAGE		RWOOD DR		
· ····································	- XCHANE	OSMHOC	N'CITY, TN	37601	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
N 69	B Continued From pa	ge 16	N 698	the NHA S/17/17.	
				4. How does the corrective CO.	nt.
ı	t optained by the wol	h there were no weights ght team, and the CDM	ļ	action(s) will be monitored to	
	renorted this to the	Administrator and DON in		ensure the deficient practice will	
	morning meetings.	Administrator and DOM III	[.	not recur; i.e. What quality	
	1			assurance program will be put in	
	Interview with the A	dministrator and the Director]	place.	
	ু of Nursing (DON) a	л 5/12/17 at 3:15 PM, outside	<u> </u>	Beginning 5/24/17 the NHA	
	of the Administrator's office, co	's office, confirmed only 2	}	implemented an audit to be done	
	 weights were obtair 	ned during Resident #51's stay		weekly by the Administrative	
!	at the facility.	•		Assist/Pt Rep. to ensure that weig	
			[are being completed on admission	ì
	on 5/45/47 at 0.50	sed Practical Nurse (LPN) #6	ŀ	then weekly then monthly as	
	on 5/15/17 at 9:56 AM, at the downs desk, confirmed he was aware of R	Avi, at the downstairs nurse's	<u> </u>	Indicated. The MD will initial the	
	1 Door intake and did	not notify the Nurse	·	weight log and will be advised of	anv
	Practitioner (NP) or	the physician		significant weight losses/gains so	any .
		are brigardan.		interventions can be implemente	d If
	Interview with LPN:	#7 on 5/15/17 at 9:56 AM, at		needed. Beginning 4/3/17 the Ni	4A .
	<u>the downstairs nurs</u>	e's desk, confirmed she was	•	and DON implemented an audit of	of .
	i aware of Resident #	\$51's poor intake and did not		the meal percentage sheets, weight	hr
	notify the NP or the	physician.		logs, weekly weights to be	
		_	·	completed by the Admin. Assist/F	> + •
	Interview with Certif	ied Occupational Therapist		Rep that will be used at the weel	dv :
	Assistant (COTA) #	1 on 5/15/17 at 10:01 AM, in		weight meeting to ensure that the	e ;
	uite upstairs dayroor	π, revealed COTA#1 worked		Medical Director has been notifie	- d
	Further intensions re-	uring his stay in the facility. vealed Resident #51 mostly		of significant weight losses/gains.	; ,
	picked at his food	vealed Resident #51 mostly preferred smooth consistency, (,	Audits will be performed weekly t	by :
	and did better with f	inger foods due to his		the Admin Assist/Pt Rep x 8 then	
	impaired vision. Cor	ntinued interview with COTA		monthly thereafter.	1 ±
	#1 confirmed she di	d not report to the RD he		Beginning 5/18/2017 the DON &	; -
	wasn't eating "tha	is nursing's job"		Nursing Supervisor checked all	i
	1			resident's chart for any missed	<u>;</u>
	Interview with NP#1	on 5/16/17 at 11:21 AM in		documentation on meal percentag	ges į
	the small conference	e room, revealed NP #1 was		and documentation of weights and	d
	in the facility Monda	y through Friday each week.		medications not documented. The	ere :
	Further interview rev	realed new admission	ļ	were no residents with missed	:
	residents were weig	hed weekly for 4 weeks and		documentation of meal percentag	ės, į
	i men monthly. Contin	nued interview revealed NP		weights or meds. These checks wil	
	#1 usually received	reports from Nursing		be done daily for 4 weeks then	cont.

Duplicate

STATE FORM

LW9W11

If continuation sheet 17 of 28

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED A. BUILDING: _ TN9002 B. WING 05/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GODE 2012 SHERWOOD DRIVE CORNERSTONE VILLAGE JOHNSON CITY, TN 37601 SUMMARY STATEMENT OF DEFICIENCIES {X4) ID { PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX : (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR USC IDENTIFYING INFORMATION) TAG DEFICIENCY N 698 Continued From page 16 randomly on a monthly basis. If any cont. N 698 documentation is not done the staff February and March there were no weights nurse or C.N.A. responsible for the obtained by the weight team, and the CDM missed documentation will be reported this to the Administrator and DON in required to return to work to morning meetings. complete documentation. The goal of the audit will be 100% Interview with the Administrator and the Director compliance. If the goal is not met, of Nursing (DON) on 5/12/17 at 3:15 PM, outside of the Administrator's office, confirmed only 2 then the identified staff member weights were obtained during Resident #51's stay who is not meeting the goal will be at the facility. re-educated. Continued failure to comply with the goal by the Interview with Licensed Practical Nurse (LPN) #6 identified employee will result in on 5/15/17 at 9:56 AM, at the downstairs nurse's progressive disciplinary action. desk, confirmed he was aware of Resident #51's Beginning May, 2017, the DON will poor intake and did not notify the Nurse report monitoring outcomes of Practitioner (NP) or the physician. weight management auditing to the quarterly QAPI Committee meetings. Interview with LPN #7 on 5/15/17 at 9:56 AM, at The NHA will report to the the downstairs nurse's desk, confirmed she was Governing Body concerning audits of aware of Resident #51's poor intake and did not restraint outcomes on a quarterly notify the NP or the physician. basis beginning 6/21/2017, Interview with Certified Occupational Therapist Assistant (COTA) #1 on 5/15/17 at 10:01 AM, in the upstairs dayroom, revealed COTA#1 worked with Resident #51 during his stay in the facility. Further interview revealed Resident #51 mostly picked at his food, preferred smooth consistency. and did better with finger foods due to his impaired vision. Continued interview with COTA #1 confirmed she did not report to the RD he wasn't eating "...that is nursing's job..." Interview with NP #1 on 5/16/17 at 11:21 AM in the small conference room, revealed NP #1 was in the facility Monday through Friday each week. Further interview revealed new admission residents were weighed weekly for 4 weeks and then monthly. Continued interview revealed NP #1 usually received reports from Nursing Division of Health Care Facilities



STATE FORM

LW9W11

if continuation sheet 17 of 28

PRINTED: 06/01/2017 FORM APPROVED

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED TN9002 B. WING. 05/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2012 SHERWOOD DRIVE CORNERSTONE VILLAGE JOHNSON CITY, TN 37601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG DEFICIENCY) N 698. Continued From page 17 N 698 Supervisors or the CDM if a resident had a poor appetite. Continued interview revealed the NP was not notified of Resident #51's poor appetite, or severe weight loss until 3/24/17 the day Resident #51 was discharged to the hospital. Interview via telephone with Resident #51's physician on 5/16/17 at 1:30 PM, revealed the physician was first notified of Resident #51's poor nutritional intake on 3/23/17, the day before Resident #51 was discharged to the hospital. Further interview confirmed had the physician been notified of the poor intake, she could have made recommendations to try and increase the resident's intake and reduced the weight loss. Interview via telephone with the RD on 5/16/17 at 2:00 PM, revealed the RD ordered the multivitamin because the laboratory results dated 2/19/17 showed the resident was anemic. Further interview revealed the RD was never notified of Resident #51's poor intake or severe weight loss. Continued interview revealed the RD would have made recommendations for interventions, since the 177 pound hospital weight was on the lower aspect of the resident's Ideal Body Weight Interview with the Administrator on 5/16/17 at 3:00 PM, in the small conference room, confirmed the facility did not follow Physician's orders or facility policy to obtain weights for Resident #51 and to implement interventions for the resident with a poor appetite, to prevent \cdot severe weight loss, resulting in a 10.9% weight loss in less than a mont N 700 1200-08-06-.06(4)(x) Basic Services N 700 1. What corrective action (s) will be accomplished for those residents 6/15/17 (4) Nursing Services. found to have been affected by the cont. Division of Health Core Facilities STATE FORM Barro LW9W11

If continuation sheet 18 of 28

PRINTED: 06/01/2017 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
	- CANTON ROMBER	A. BUILDING:			PLETED
	TN9002	B. WING	· 		
NAME OF PROVIDER OR SUPPLIEF	SYPESYAN			05/	17/2017
	OTICET MD	RWOOD DR	STATE, ZIP CODE		
CORNERSTONE VILLAGE	TORNHOL	v city, yn :			
(X4) ID SUMMARY ST	ATEMENT OF OFFICIENCIES	ID			
TAG REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLE DATE
N 700 Continued From p	age 18	N 700			
			deficient practice:	COUF	•
(x) Restraints ma	y be applied or administered to		A Restraint Reduction Assessm		
teaineilis otill oti t	ne signed order of a physician		was completed for all residents		
THE SIGNED PRYSIC	lan is order must be for a life		5/12/17 by the New Risk Mana	ger,	•
specified and limite	ed period of time and must		New DON, ADON, and RN		! :
accument the Nece	35SIN of the restraint. There is		Supervisor. If any changes wer	e	
· snall be no standin	g orders for restraints.		made, a physician order were		•
			obtained as follows:		
	1		Resident #56 had a new restrai		;
This Rule is not m	et as evidenced by:]	reduction assessment complete	ea on	•
Based on facility or	olicy review, medical record	- 1	5/12/ 17 by the New Risk Mana who changed the soft belt resti	ager,	
review, observation), and interview the facility 1	l	to a "pelvic slider belt" with a	raint	
: remen to etignite bil	VSICIAN'S Orders were obtained I	1	physician order that this appara	Atua ia	•
ioi the use of restra	aints for 5 (#59 #34 #77		used for this resident's safety r	alus is	
#134, and #14) res	idents.		to a traumatic brain injury caus	ioren i	
i The Sedianal III		1	him to have spasticity and	ı.ı.È l	
! The findings includ	ed:		involuntary movement/shakes.	00	
Review of the facility	handa Barata	1	6/6/17, this resident had anoth		
7/14/16, revealed "	by policy Restraints, reviewedThe resident has the right to		restraint reduction assessment	and i	
be free from any nh	ysical or chemical restraints		the restraint was discontinued.		
i inthosen tot batbos	ICS Of discipline or J	. [was placed in a Rocking King		
i convenience, and n	of required to treat the		Wheelchair for safety and comi	fort.	
i residents medical s	VmptomsPhysical	1	Resident #59 had a restraint		
i restraints are defin	ed as any manual mathad as 19		reduction assessment on 5/17/	17 '	
I HIJSICSI OF WECKSD	ICSI device material or	1	with no changes and remains in	ıa ¦	
l ednibilieut attächeα	Of adjacent to the regidents	ſ	Gerl-chair with a tray top. On		
Which restricts from	lual cannot remove easily	J	6/6/17, this resident had a resti	raint	
access to one's had	om of movement or normal y. Physical restraints include,	ľ	reduction assessment and her	1	
but are not limited to	o, leg restraints, hand mitts,		restraint was discontinued. The		
soft ties or vests, lar	cushions, and lap trays the	1	resident was placed in a Ormed	a	
i resident cannot tem	OVE easilyI Ising devices in		Wheelchair for positioning and	1	
conjunction with a cl	hair, such as travs, tables		safety.		
pais of pelts, that th	e resident cannot remove	-	Resident #34 had a restraint		
easily, that prevent t	he resident from rising		reduction assessment on 5/17/:		
Restraints may no	t be used or applied in a	1	with no changes and remains in		
manner; which caus	es injury to the	ĺ	Geri-chair with a tray table OR a	cont.	
/ patientPhysical res	straints shall be checked	ļ.	wheelchair with a soft belt restr	aint	

LW9W11

If continuation sheet 19 of 28

Division of Health Care Facilities STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED TN9002 B. WING 05/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2012 SHERWOOD DRIVE CORNERSTONE VILLAGE JOHNSON CITY; TN 37601 - - (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY N 700 Continued From page 19 N 700 cont. per daughter's (employee) request. every (30) minutes and released every two (2) On 6/6/17 a restraint reduction hours so the resident may be exercised and assessment was completed and her offered toilet access... A signed, dated, written restraint was removed and placed in physician order shall be required for a physical a Broda Tilt chair for safety and restraint. This order shall include the type of comfort. restraint to be used, reason for use...Restraint Resident #77 had a restraint use will be assessed by the interdisciplinary team reduction assessment on 5/5/17 and on admission and readmission and at least quarterly for elimination, reduction or continued soft belt restraint discontinued. need based on resident's condition..." Resident #83 had a restraint reduction assessment on 5/17/17 Medical record review revealed Resident #59 was with no changes and remains in a admitted to the facility on 8/10/15 with diagnoses soft belt at the husband's request. including Hypertension, Alzheimer's Dementia, Resident #145 had a restraint Anxiety, Depression, and Psychosis. reduction assessment on 5/5/17 with no changes and remained in a Medical record review of the physician's order Soft belt due to a fall risk. On dated 2/26/16 revealed "Failed reduction-Geri 5/15/17 Resident was discharged to chair [Gchair] with tray table due to poor safety ACLF. awareness, multiple falls. DX [Diagnosis] Resident #145 was discharged to dementia". Assisted Living on 5/15/17. Resident #100 had a restraint Medical record review of the Pre-Restraining reduction assessment on 5/17/17 Evaluation dated 2/26/16 revealed "...w/c [wheelchair] with lap buddy-failed-Gchair with tray with no changes and remains in a soft belt restraint. On 6/6/17 a 2/29/16..." restraint reduction assessment was done and her restraint was Medical record review of Resident #59's care plan discontinued to a Dyn-Scooter Chair dated 2/29/16, revealed "...Geri chair with tray top for safety and comforter. up...Review my restraint use quarterly and prn [as Resident #134 had a restraint needed] for potential reduction... reduction assessment on 5/5/17. A reduction was attempted but was Observation on 5/8/17 at 4:15 PM, in the 500 not successful so restraint was hallway near the elevator revealed Resident #59 reordered on 5/11/17 and remains was seated in a wheelchair with a soft lap belt in place. On 6/6/17 another restraint applied (not in a geri chair with tray top). Resident reduction assessment was #59 had slid down in the wheelchair with the soft completed and resident was placed lap belt around her chest, just under her breast. in Broda Pedal Rocker for safety and cont. Division of Health Care Facilities

STATE FORM

6800

LW9W11

If continuation sheet, 20 of 28

Divisio	on of <u>Health Care Fac</u>	ililies			I ORN	MAPPROVED
STATEM	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLICE/CEA	LIX2) MURTI	IPLE CONSTRUCTION	·	
1 0000	an on condition IDM	IDENTIFICATION NUMBERS	A. BUILDIN			E SURVEY PLETED
-			The Boxesii	·····	001	a cacted
	_	TN9002	a. Wing			
NAME O	F PROVIDER OR SUPPLIER		 ,		05/	17/2017
<u> </u>	WARREN OR SUPPLIER	Office A		/, STATE, ZIP COBL		_
CORNE	ERSTONE VILLAGE	2012 SH	EKWOODD	TRIVE	·	*
		JOHNSO	N CITY, TN	37G01		
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECT	TITIM	·
IAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	EACH CORRECTIVE ACTION SHO	OR OTHER	COMPUTE
J.,	<u>:</u>		IAG	CROSS-REFERENCID TO THE APPL DEFICIENCY)	ROPRIATE	DAN:
N 700	O Continued From pa				<u> </u>	<u> </u>
			N 700	comfort	cont.	}
	Interview with Regis	stered Nurse (RN) #1 on		Resident # 14 had a restraint		1
Ì	- 5/8/17 at 4:15 PM i	n the 500 hallway near the	1	reduction assessment on 5/17/1		
1	cicvator, revealed [he RN did not identify the	-	which was discontinued on 5/17	.7	
	resident had been p	placed in a restraint that had	1	Resident #52 has a restraint	/1/.	1
1	nor need ditteled 9	nd the resident had not been		reduction assessment on 5/17/1	-,	i l
	Concessed for the da	e of this type of restraint.	1	with no changes and the soft be	. / Ia	
1	Interview with LPN:	#2 on 5/8/17 at 4:25 PM, on	}	remains in place. ON 6/6/17, thi	L	i i
	the 500 hallway nea	er the elevator, did not identify	1	resident was transferred to the	5 1	i l
1	mie tealdout uad De	en blaced in an incorrect		hospital for acute care treatmen	ocai •	
	 restraint and confine 	ned the restraint was		Resident #108 had a restraint	ξ.	1 1
	positioned too high	on the resident.		reduction assessment on 5/1//3	7	1
,	:			with no changes and the soft bel	<i>'</i>	
;	Observation and int	erview with CNA #1 on 5/9/17		remained in place until 5/27/17	τ	1
4	; at 4:25 PW, on the {	500 hallway near the clovator	ĺ	when soft belt was reduced to a		ļ [
4	. revealed the lap bet	t could be at chest laval		pommel cushion with dycem whi	3 !	<u> </u>
:	i because the resider	if was small and she scoots		the wheelchair. On 6/6/17 a	ite: In	i 1
4	i don'i kumumba m	.She is usually in a geri chair,	l	restraint reduction assessment w	***	ľ
i	belt"	t her in this chair with the]	completed and the restraint was	105	· ·
			ļ	discontinued. The resident was		1
	Interview with CNA	#2 on 5/11/17 at 1;26 PM, in a	ŀ	placed in a Broda Peddie Rocker is)r	
	resident room near (the upstairs dining area,		salety and comfort.		1 1
	TOACSIGG CIMA #5 00	t Resident#59 out of the had	!	The three resident's (#59, #34, and	ri	
] on arriver in the after	™00n, placed Residont#50 – i		#77) who were identified during	-] [
) in the wheel chair, a	nd applied the soft hot		survey with restraints in use which	1 :	
	t restraint "i didut ki	NOW. (Wrong restraint) national		were not the correct restraint, the		1
	went bast	3 full time CNAs and thev		Risk Manager immediately correct	ed	
[didn't say anything	when we do rounds they just		their restraint to the correct type of	ρΓ	
	it libert dock are dry, si	ick, that's the extent of		restraint 5/9/17.		
	i charey don't say anj	thing about restraints"		The three residents (#56, #59 and	ĺ	
	Medical record review	w revealed Resident #34 was		#108] who were identified during	ļ]
 	admitted to the facilit	y on 7/6/15 with diagnoses		survey as having restraints applied	in	- !
	including Hypertensia	on, Dementia, Psychosis,		an unsafe manner during survey, h	ad	
	Schizophrenia, Anxie	elv and Depression		these restraints removed and	\$	
		· · · · · · · · · · · · · · · · · · ·		correctly applied on 5/09/17 by RIs	k ¦	İ
	Medical record review	w of the physician's orders		Manager. The one resident (#34)	ļ	!
1	Trom 2/11/16 to 5/11/	17 and Interview with LPN #1 L	ľ	Who was identified during survey a	s cont.	ĺ
<u>_</u>	on 5/11/17, at 9:00 A	M, near the upstairs nurse's		showing signs of agitation by	COIL	

Division of Health Care Facilities

STATE FORM

650:

TW9W11

If continuation shoot, 21 of 28

Divis	ion of Health Care Fac	ilities				APPROVED
STATE	MENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/X2\ MI II TII	PLE CONSTRUCTION	г	
ANDPI	AN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE	
		1	A POILDIN	8:	COMP	LETED
		TN9002	8. WING		ļ	
NAME	OF PROVIDER OR SUPPLIER		<u> </u>		05/1	<u>7/2</u> 017
		STREET AD	DRESS, CITY	, STATE, ZIP CODE		<u> </u>
CORN	IERSTONE VILLAGE	2012 SHE	RWOOD D	RIVE	·	
(X4) II	CUMMACU	JOHNSOI	N CITY, TN	37601		• • • • • • • • • • • • • • • • • • • •
PRÉFI	X (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	JD	PROVIDER'S PLAN OF CORRECTION	ON I	6/6
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SMOUL CROSS-REFERENCED TO THE APPROI	noe i	(X5) COMPLETE
 		······	{ "	PEFICIENCY)	-RIATE	DAYE
N 70	Continued From pa	ge 21	N 700		<u></u>	
1			14,000	pushing on the restraint tray table	cont.	
· • ·	place for Regident	physician's orders were in	,	had the tray removed on 5/11/17		
1	with a table top in p	#34 to be placed in a geri chair		due to no physician order.	·-·· ļ	,
ľ	i a rapid tob til b	idce,		2. How you will identify other	- 1	
	Medical record revie	w of the Physician's Order		residents having the potential to b	۱ م	
1	valed 3/3/1/ Tevesi	BC "(1) Discontinue Cort above (affected by the same deficient	_	
	- 3 With BOX LOD WITER A	\ T^7 D^7 \frac{1}{2} \ \ \ \ \ \ \ \ \ \ \ \ \		practice and what corrective action	, 1	
	* Arm sold Maist Belt s	and anti-finners when out of		will be taken.		
	ு bed as tolerated." (ர	no reason/diagnosis stated)		On 5/12/17 the DON, ADON and Ris	ik	,
ľ		· 1		Manager reviewed all residents wh	o	i
]	: Unstairs dining organ	erview with CNA#14 in the		have restraints in the facility for		- 1
1	revealed Resident #	on 5/8/17 at 12:00 PM,		appropriate assessment for	.	
Į	Chair, with an attach	34 seated in a reclined geri ed table in place, waiting for		Implementation of a restraint,	}	
	the lunch meal, and	pushing on the table.		physician orders for the identified	}	Į.
	: interview with Cina #	#14 revealed "two above and		restraint, restraint reduction, if		ł
	the tables up on the	geri chairs for lunch."		possible or alternative type or		j
1	3			downgrade, continuation of the		
	Observation on 5/9/1	17 at 9:10 AM, 11:00 AM,		restraint and care planning along	ľ	- 1
1	1 14:40 FW, 4:30 PW.	and on 5/10/17 at 8-nn AM		with correct restraint application.	ļ	1
	THE PURPOSE PARTY IN THE A	Mining area coveries	}	Any issue regarding the restraint	-	ľ
ĺ	i attached table in place	eclined geri chair with the		usage that was identified was	ĺ	ŀ
	asked to have the tal	ce, slightly agitated, and		reported to NHA and/or Medical Director.	- 1	Ì
	observation revealed	the tray table was not	[3. What measures will be put in		
	removed,	way table was flot	1	place or what systematic changes		
		1	ļ	will you make to ensure that the	[- 1
	Medical record revieu	w revealed Resident #77 was	.	deficient practice does not recur:	ĺ	
	Tre-adminged to the 190	XIIIV on 5/13/16 with	ł	On 5/17/17 the NHA, New DON,		Ì
	uragrioses including (Concestive Heart Fallura		ADON, House Supervisors reviewed		- 1
	Disease	and Peripheral Vascular		and revised the Policy and procedure	. [-
	Discese,	1	1	for Restraint Management including	-	
	Medical record rovious	y of Dhystataula Carl	ł	usage and physician notification.	.	1
	dated 3/28/17 reveals	v of Physician's Orders ed "May use soft waist		On 5/09/17 the NHA in-serviced the	- 1	1
	[restraint] while up in	wheel chair" (no reason or		new DON, Assistant Director of	- 1	ļ
	diagnosis stated)	moor onail (No reason or		Nursing, Restraint Manager, House	ĺ	!
	•		1	SV, Medication Nurses and C.N.A.s		
	Medical record review	of the physician's order	1	on restraint application	ľ	ļ
Testa ta a de de	i dared ototal Levealed	"Check resident lower		requirements per the facility's policy	cont	1
IVISION OF H TATE FORI	ealth Care Facililles					

LW9W11

If continuetton sheet 22 of 28

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: __ COMPLETED TN9002 B. WING 05/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2012 SHERWOOD DRIVE CORNERSTONE VILLAGE JOHNSON GITY, TN -37601-SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY N 700 Continued From page 22 N 700 and procedure and the correct cont. extremities daily @ [at] 10 AM, if pitting edema is application process. present, resident is to be in geri chair when out of On 5/12/17 the NHA, DON, Risk bed." Manager conducted a mandatory inservice on the facility's Restraint Observation and interview with CNA#14 on policy to all nursing staff (RNs, LPNs, 5/11/17 at 8:30 AM, in the upstairs dining area, revealed Resident #77 sitting in a geri chair with & CNAs) . No staff will work until the tray table in the up position. Interview they have received this education. confirmed the resident was sitting in the geri chair The Don & ADON will reconcile it with the tray table in the up position and the CNA with a current employee roster and failed to identify the resident was supposed to be also the employee schedule. in a soft waist restraint. Effective 5/12/17, any staff who fail to comply with the points of the in-Observation and interview with LPN #1 on services will be further educated 5/11/17, at 8:35 AM, confirmed Resident #77 was and/or progressively disciplined as seated in the geri chair with the tray table in the indicated. up position, and the LPN did not recognize the After completing the mandatory inresident was to be in a soft waist restraint. service on 5/16/17, a post test was given to all RN's, LPN's and C.N.A.'s Medical record review of the Physician's Orders with Nurse Practitioner (NP) #1 on 5/11/17 at by the DON, ADON, QA Nurse and/or 10:15 AM, at the upstairs nurse's desk, confirmed New Risk Mgr. House Supervisor to there was not an order for the geri chair table top ensure understanding along with to be in the up position, restraining Resident #77. restraint application competency. Any new hires are educated during Medical record review revealed Resident #134 orientation by the DON, ADON or was admitted to the facility on 1/19/17 with Nursing SV.On 5/12/17 the NHA and diagnoses including Altered Mental Status, New DON developed an audit tool to Dementia with Behavioral Disturbance, Atrial review the restraint application Fibrillation, Schizoaffective Disorder, process in the facility. This audit tool Hypertension and Hypothyroidism. will be completed by the Risk Manager, RN Supervisor, or Unit Medical record review of a physician's order Manager, Beginning 5/12/17 the dated 3/28/17 revealed "...may use soft waist belt Restraint Usage Report will be while up in chair..." reviewed weekly by the NHA at the weekly Restraint meeting. Medical record review of a physician's order 4. How does the corrective action(s) dated 5/5/17 revealed "...Discontinue Soft waist will be manitored to ensure the belt while in wheel chair...place chair alarm in cont. deficient practice will not recur; i.e. wheel chair... " Division of Health Care Facilities

STATE FORM

8840

LW9W1t

If continuation sheet 23 of 28

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (Xt) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING, TN9002 . 8. WING 05/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CHY, STATE, ZIP CODE 2012 SHERWOOD DRIVE CORNERSTONE VILLAGE JOHNSON CITY, TN 37601 SUMMARY STATEMENT OF DEFICIENCILS (IX4) ID PROVIDER'S PLAN OF CORRECTION ID (X6) COMPLETE PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREI IX (LACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) IAG ING CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 700! Continued From page 23 N 700 cont. What quality assurance program Review of Resident #134's Care Plan, last will be put in place. revised on 5/5/17, revealed "...discontinue soft waist belt while in wheel chair..." Beginning 5/17/17, the new Risk Manager will audit the medical Observation on 5/10/17 at 2:30 PM, in the record of any residents with a resident's room, revealed the resident seated in a : restraint weekly x 4, then monthly wheel chair with a soft lap belt applied. thereafter to ensure attending physician has been notified of the Interview with LPN #f on 5/10/17 at 2:40 PM, in need for a restraint, assessment the resident's room, confirmed the resident had a † prior to implementation of the soft lap belt applied and did not have a current restraint, restraint reduction Physician's Order for the soft belt restraint, assessment is occurring timely, the Continued interview confirmed the soft lap belt was discontinued on 5/5/17. Further interview need for continuation of the revealed it was procedure to communicate restraint and that the resident's care changes during shift change and all Certified plan has been updated appropriately Nurse Aides (CNA) "...should be aware of a for the restraint. The goal of the change..." audit will be 100% compliance. If the goal is not mot, then the Interview with CNA#3 on 5/10/17 at 5:25 PM, at identified staff member who is not the upstairs nurses station, confirmed she was meeting the goal will be reassigned to Resident #134 and was aware of the educated. Continued fallurg to new order to discontinue the tap belt. Continued comply with the goal by the interview confirmed she asked for CNA#10 to identified employee will result in assist with the resident and she did not apply tho progressive disciplinary lan belt. Beginning In May, 2017, the DON will report monitoring outcomes of Interview with CNA#10 on 5/10/17 at 5:30 PM, at restraint management auditing to the upstairs nurses station, confirmed he was not aware of the order to discontinue to soft lap belt. the quarterly QAPI Committee Continued interview confirmed he assisted the meetings. The NHA will report to resident but did not apply the restraint. the Governing Body concerning audits of restraint outcomes on a Medical record review revealed Resident #14 was quarterly basis beginning 6/21/17. admitted to the facility on 8/4/15 with diagnoses to include Dementia without Behavioral Disturbance, Anxiety Disorder, Type 2 Diabetes, and Insomnia. Medical record review of the Interdisciplinary Notes dated 2/18/17 revealed "... Soft belt is in Division of Health Care I scrilling STATE FORM

6490

CW9W11

If continuation sheet, 24 of 28

PRINTED: 06/01/2017

STAT	EMENT OF DEFICIENCIES	-			. 010	M APPROVI
AND	FLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	r	IPLE CONSTRUCTION NG:	(X3) DAT	E SURVEY MPLETED
<u> </u>		TN9002	B. WING	·		
NAME	OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CIT	Y. STATE, ZIP CODE	<u>j 05</u>	/17/2017
COR	NERSTONE VILLAGE	2012 \$F	ERWOOD (DRIVE	-	
		- JOHNS	ON CITY, TN	1 37601 ····· · · · · · · · · · · · · · · · ·		
(X4) PREI TAI	FIX (EACH DEFICIENCY G REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT	D OF	(X5) COMPLET DATE
N7	Continued From pa		N 700			-!
	place when residen given).	t up in chair" (no reason	<i>.</i>			
	TOWN IN THE UDSTAIRS (ident #14 on 5/8/17 at 11:30 dining room, revealed the wheel chair with a soft lap				
	in the upstairs dining	dent #14 on 5/9/17 at 9:10 PM, 4:30 PM, and 5:10 PM, room, revealed the resident pair with a soft lap belt in				
	L 41.4 abstall 2 UNI 262 5	1 on 5/10/17 at 9:25 AM, at station, confirmed there was er for the soft belt lap		•		
	THE CONTRACT THE SEC O	1 on 5/10/17 at 3:15 PM, at station, confirmed sees will put something				
N 70	07 1200-08 - 06-,06(5)(b)	Basic Services	N 707	What corrective action (s) will be	ĺ	
	(5) Medical Records.			dccomplished for those residents		6/15/17
	be accurate, promptly and retained, and accuse a system of autho maintenance that ens	e must maintain a medical ent. Medical records must completed, properly filed ressible. The facility must or identification and record ures the integrity of the otects the security of all		found to have been affected by the deficient practice: The medical records for residents #64 and #133 were reviewed for accuracy. Resident #133 was discharged on 3/20/17 therefore no other information could be placed in the closed medical record. Resident #64 Ruby Ford had her medical record reviewed and updated with any available information as of 6/1/17.	cont	

LW9W11

If continuation sheet 25 of 28

ΕΛΙΝΙΈυς συντίεστη ΕΛΙΝΙΔΕΡΡΟΜΕΝ

	Divisio	on of Health Care Facilities					FORM APPROVED		
	I STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA						
	AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TPLE CONSTRUCTION NG:	TAG (SX)	E SURVEY IPLETED		
	Ì		The state of the s				" CELED		
			TN9002	B. WING_					
	NAMEOF	PROVIDER OR SUPPLIER	STREET	INDRES OF	Y, STATE, ZIP CODE	<u> 1 05/</u>	17/2017		
_	CORNE	RSTONE VILLAGE	2012 St	ERWOOD I	r, STATE, ZIP CODE				
		MOTORY VILLAGE		ON CITY; Th					
	(X4) ID	SUMMARY STAT	FMENT OF DEPARTMENT	- -					
	PRÉFIX TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER CONTROL OF THE APPROVIDER C	O DO	COMPLETE DATE		
	N 707	Continued From pag	je 2 5	! N 707	2. How you will identify other	-	' <u></u>		
	-	· -		14707	residents having the potential to be	cont.			
		This Rule is not me	fac evidances by		affected by the same deficient	3	i 1		
-		Based on medical re	ecord review, observation,	1	practice and what corrective action		i 1		
- {		and interview, the fa	cility failed to maintain an	ļ	will be taken.		[
- 1		accurate medical red	cord for 2 residents (#64 and		All other resident's medical records		i i		
-		#133).	to be residents (#04 and		were reviewed by members of		i		
	ļ			'	Nursing SV for accuracy by 6/6/17		;		
- 1	ļ	The findings included	d:		and updated if needed.		i		
-		Madiest L .		:	3. What measures will be put in] [
	Į	Medical Lecold Levier	revealed Resident #64 was	•	place or what systematic changes				
- }	1	including Demantic	y on 9/30/16 with diagnoses	with diagrams	Will you make to ensure that the		<u> </u>		
	ŀ	Depression, and Anx	Anemia, Heart Failure,		deficient practice does not recur:	į	!!!		
Ĺ		- this colord and Milk	iety.	į	Policy and procedure for daily				
-	Ì	Medical record review	v of Resident #64% Day		charting in the resident's medical				
	F	Medical record review of Resident #64's Daily Charting (electronic Certified Nursing Aide			record were reviewed and undated if	.			
		evenuentalious date	M 4/1/17 - 5/0/47		needed as of 6/6/17 by the NHA	ļ			
J		TO DIDITIV SECTIONS IN I	MO PERSONAL BYCIENC	1	DON, ADON and Medical Director. A	İ			
	I .	Ciai cale under the s	Signature & Date/Notes	Ì	Systematic process to ensure that	- 1			
		williams, indicating th			Charting has been completed by the		į		
	· · · · · · · · · · · · · · · · · · ·	as performed by staff			certified nursing assistants and	- 1	1		
1	J	Intention with the Di-			Shower team will be to educate	ļ	i		
ĺ],	5/11/17 at 7:25 AM to	ector of Nursing (DON) on the conference room,		them on the requirement to	- 1	.		
	Į,	Confirmed no docume	ntation in the CNA Daily		complete charting and	İ	.		
1		Charting oral care was	s completed on 20		documentation before they leave	ĺ	1		
1	- 0	occasions from 4/1/17	7 - 5/9/17 where the		their shift each day. If any staff	- 1			
Ţ	, ,	signature sections we	re blank.		member has been found to have not		i		
1	- 1				completed their charting, and they		ĺ		
	[]	viedical record review	revealed Resident#133		have left the facility, they will be		1		
1	j v	vas autilitied to the fa	Cility on 1/43/47 with	ا	called to return to complete charting	1]		
	1 4	iiayiioses including C	htonic Atrial Ethrillation	;×"	as required. If the staff member	- 1	1		
1	1.	ozneimers Disease, I Disorder.	Diabetes, and Anxiety	[refuses to return to complete		ľ		
	15	APPINDI.	ļ	[required charting/documentation		ļ		
	ļ _T	he resident was disa	tarand on Blocks	ŀ	utey will be given corrective action		j		
Į	'	he resident was disch	larged on 3/20/17.	ľ	All dualt Will be put in place by the	- 1	ſ		
	l R	eview of the Showers	Form and Activities of		DON, ADON OF Nurse Stro enguro		ļ		
ł		aily Living (ADL) She	ets revealed the resident	1	That all charting has been completed	Į	ł		
	110	retived a silower on "	1/25/17, 1/31/17, 2/3/17	1	in a unitely manner. The audit will	I	ĺ		
Divis	olon of Healt	h Care Facilities			occur daily x 4 weeks then monthly	cont.	1		

STATE FORM

6600

LW9W11

If continuation sheet 26 of 28

PRINTED: 06/01/2017 FORM APPROVED

TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	ICIENCIES (X1) PROVIDER/SUPPLIER/CI,IA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
·	TN9002	B. WING	··-	054	7/00 AW
AME OF PROVIDER OR SUPPLIL	R STREET A	DORESS, CITY.	STATE, ZIP COUL	1 05/1	7/2017
ORNERSTONE VILLAGE	2012 SH	EKWOOD DI	RIVE		
	JOHNSO	N'CITY, TN	37601		
TAG REGULATORY OR	PATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (FACH CONTROL INVESTIGATION SHOUL CROSS-REFERENCED TO THE APPRO DELICIENCY)	ines 1	XX) CAMPA CAMPA
Indeview, the accurate medical and interview, the accurate medical at #133). The findings included Medical record revial admitted to the faction including Demential Depression, and At Medical record revial Charting (electronic documentation), da 20 blank sections in Oral Care under the columns, indicating as performed by standard processions from 4/1/signature sections vial medical record reviews admitted to the diagnoses including Alzheimer's Discassions of the Show Review of the Show Review of the Show including Review of the Sho	net as evidenced by: record review, observation, facility failed to maintain an record for 2 residents (#64 and led: lew revealed Resident #64 was ility on 9/30/16 with diagnoses a, Anemia, Heart Failure, recipitation of Resident #64's Daily c Certified Nursing Aide ated 4/1/17 - 5/9/17 revealed in the PERSONAL HYGIENE e Signature & Date/Notes the care was not documented aff. Director of Nursing (DON) on in the conference room, mentation in the CNA Daily vas completed on 20 17 - 5/9/17 where the	N 707	thereafter. The goal of the audit will be 100% compilance. If the go is not met, then the identified staff member who is not meeting the go will be re educated. Continued failure to comply with the goal by the identified employee will result progressive disciplinary action. 4. How does the corrective action will be monitored to ensure the deficient practice will not recur; i.e What quality assurance program will be put in place. The DON, ADON or Nurse SV will audit the Certified Nursing Assistant for completion of their documentation in the resident's medical record and or ancillary sheets. The results of the audit will be presented monthly to the Quality Assurance /Performance Improvement Committee meeting monthly by the DON beginning in May 2017. The results of the audit will also be presented to the governing body on a quarterly basis by the NHA. beginning 6/21/17	af in s)	

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: __ COMPLETED TN9002 B. WING 05/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2012 SHERWOOD DRIVE CORNERSTONE VILLAGE JOHNSON CITY, TN 37601 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 707 Continued From page 26 N 707 2/6/17, 2/8/17, 2/22/17, 2/25/17, 3/6/17, 3/10/17, and 3/13/17. Interview with the DON on 5/11/17 at 7:30 AM in the conference room confirmed there was no documentation the resident received a bath the week of 2/12/17-2/18/17. N1535 1200-8-6-.15(4) Nurse Aide Training and N1535 1. What corrective action (s) will be 6/15/17 Competency Evaluation accomplished for those residents found to have been affected by the (4) Continued Competency. deficient practice: The facility must complete a performance review Beginning 5/12/17 and ending of each nurse aide employee at least once every 5/17/17 the DON, RN Supervisor, 12 months and must provide regular in-service and Nursing Management education based on the outcome of these completed competency skills reviews. checklist on Certified Nursing Assistants that were identified during survey as not have their This Rule is not met as evidenced by: Competency \$kills Check List which Based on review of the Certified Nursing put resident's #56, #59, #34, #77, Assistant Competency/Skills Check List and #83, #145, #100, #134, #14, #52, and interview, the facility failed to ensure 33 of 41 #108 at risk. These competencies Certified Nursing Assistants had a Certified also included a checked off for Nursing Assistant Competency/Skills Check List, proper restraint application. including types of restraints and return demonstration of restraint application completed. 2. How you will identify other residents having the potential to be affected by the same deficient The findings included: practice and what corrective action Observation and interview during the annual will be taken. survey 5/8/17-5/17/17 revealed: Resident #56 Any other new Certifled Nursing had an incorrectly applied lap belt restraint on Assistant that are hired will have a 5/9/17 and 5/11/17 which allowed the resident to Competency/Skills Check List slip under the restraint, placing him at risk for Completed during Orientation or entanglement in the restraint, Resident #59 had during the first 90 days of an incorrectly applied soft lap belt restraint on employment during their evaluation. 5/8/17 which allowed the resident to slide down in process by the DON, RN Supervisor cont. Division of Health Care Facilities

STATE FORM

LW9W11

If continuation sheet 27 of 28

г	DIVISION	<u>i of Health Care Faci</u>				FORM APPRO	٧ĘD
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING:		(X3) DATE SURVEY	
		_	TN9002	B, WING			
-	NAME OF	PROVIDER OR SUPPLIER				05/17/2017	
- -	<u>-</u>				STATE, ZIP CODE		
٠L	COKNE	RSTONE VILLAGE		RWOOD-D	37601		
Г	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				٠.
	PREFIX TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REPERENCED TO THE APPROP DEFICIENCY)	195 coveri	ETE
-	N1535	Continued From page	ge 27	N1535		1	
		the wheelchair with the soft lap belt around her			and/or nursing management. A	cont.	
-	i	cnest, placing her ai	t risk for chest compression:		C.N.A. will not be allowed to wor	k .	
		and Kesident#108	had an incorrectly anniled soft i	}	until they complete a restraint	· ·	
		iab per ou 2/8/17 bi	acing the resident at risk for		application check-off.	1.	
		entanglement in the	restraint.		3. What measures will be put in	ŧ	
		Observation and !-+	and the state of t		place or what systematic change	s	
1		SUIVEY 5/8/17-5/17/4	erview during the annual 17 revealed : Resident #59		will you make to ensure that the		
		Was observed on 5/6	8/17 with a soft lap belt in		deficient practice does not recur	;	
		piace, without a phy:	sician's order or an i		On 5/17/17 the NHA revised the	;	
-		assessment comple	ted for the soft lan both		process on all new hires of Certif	ied ,	
	-	Resident#34 was o	bserved on 5/8/17 5/9/47 !		Nursing Assistants will have a Competency/Skills Check List		
		and o/10/17, seated	In a reclined peri chair with		Completed during Orientation or	i	
ı	an attached table in		Diace, Without a physician's		during the first 90 days of	:	
	1	Resident #77 was at	with an attached table; bserved on 5/11/17 seated in		employment during their evaluation	_ :	:
		a geri chair with a tra	ay table in place without a		process. This process will be	on j	
	ļ	physician's order: an	and Resident #134 was 17 with a soft lan helt in place		monitored by the Human Resource	. !	
	upserved on 5/1	upserved on 5/10/17			Director. The C.N.A. will not be	i	
1		without a physician's	order for the soft lap belt.		allowed to work until this restraint		
		•		competency Check Offs has been			
1		Review of the Certific	ed Nursing Assistant		completed.		
		Nursing Assistant Co	heck List revealed Certified		Effective 5/17/17 the NMA educate	ed !	
	1	Were completed for F	ompetency/Skills Check Lists of 41 Certified Nursing		I DIG DON, Assistant DON and Staffin	ng !	
ļ		Assistants.	octobro Mutalifi		Coordinator concerning the new	ļ	ŀ
1	ł		1		requirement that the Certified	. 1	
	1	Interview with the Dir	ector of Nursing on 5/15/17		Nursing Assistant will not be allowe to continue working if their	đ	- 1
	1	at Ziliu Pivi, in the col	inference room, confirmed 33 l	ł	Competency/Skilled Check Off list	1	-
	١,	or 4 r cermied Millsh	id Assistant		has not been completed during the	j	-
-		Competency/Skills Completed.	neck Lists were not	}	90 day evaluation period.		
	[]		ł		4. How does the corrective action(c	n	-
	-			- 1	will be monitored to ensure the	i	
				.	deficient practice will not recur: (.e.	. !	
ĺ]	what quality assurance program	' ·	
ļ	- 1		!	ļ	Will be put in place.		
	{		<u> </u>	ſ	An audit by the DON or designee wil	, }	Į
l	- 1		l	,	be put in place that will ensure that		
L Djyjs	lon of Hea	Ilh Care Facilities				cont.	
STA	TE FORM						

LW9W11

If continuation sheet 28 of 28

CODE A SAMOUNE IN

Division of Health Care Facilities					FORMAPPROV		
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIP A, BUILDING	PLE CONSTRUCTION 3:	(X3) DATE COMP	SURVEY LETED	
		<u> TN9002</u>	B. WING_				
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY.	STATE, ZIP CODE	05/1	7/2017	
CORNER	RSTONE VILLAGE	2012-SHE	מרםססשא	RIVE	 		
(X4) ID		UOHNSO	N GITY, TN.	37601			
PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	. ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)	DULORE	(X5) COMPLETE DATE	
F C N A II a coi	the wheelchair with chest, placing her a and Resident #108 lap belt on 5/8/17 pl entanglement in the Observation and into survey 5/8/17-5/17/19 was observed on 5/8/18 was observed on 5/8/18 was observed on 5/8/18 was observed on 5/10/17, seated an attached table in order for a geri chair with a trachysician's order; an observed on 5/10/17 without a physician's Review of the Certific Competency/Skills Clursing Assistant Colvere completed for 8 was istants.	the soft lap belt around her trisk for chest compression; had an incorrectly applied soft acing the resident at risk for restraint. erview during the annual if revealed: Resident #59 B/17 with a soft lap belt in sician's order or an ted for the soft lap belt; belt in section of the soft lap belt; belt in a reclined geri chair with place, without a physician's with an attached table; belt in place without a desident #134 was with a soft lap belt in place, order for the soft lap belt. Ed Nursing Assistant heck List revealed Certified impetency/Skills Check Lists of 41 Certified Nursing assistant heck List revealed Certified impetency/Skills Check Lists of 41 Certified Nursing assistant heck List revealed Certified impetency/Skills Check Lists of 41 Certified Nursing assistant heck List revealed Certified impetency/Skills Check Lists of 41 Certified Nursing assistant heck Lists of Assistant confirmed 33 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed 34 and the confirmed	N1535	all Certified Nursing Assistants their Competency/Skills check completed in a timely manner audit will occur on a weekly be weeks then 1 x monthly there. The DON or designee will audit CNA checklist and submit outcat the QAPI committee meeting goal of the audit will be 100 compliance. If the goal is not meeting goal will be reeducated. Continued failure comply with the goal by the identified employee will responsive disciplinary actic Beginning May, 2017, the DON report monitoring outcomes of restraint management auditing the quarterly QAPI Committee meetings. The NHA will report the Governing Body concerning audits of restraint outcomes on quarterly basis beginning 6/21/5	s have s have cont. s have cont. s have cont. s have cont. s have asls x 4 after. lit the comes ng. The low of ff g the ult in on. will s to		
Division of Health	i Care Facilities						

DUPlicate

LW9W11

6030

If continuation sheet 28 of 28